Exploring the Phenomenology of Clinical and Non-Clinical Depression: A Q-Methodological Study

Ian Hodges

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Statement of Authorship

This thesis is written by Ian Hodges and has ethical clearance from the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University. It is submitted in partial fulfilment of the requirements of the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University for the Degree of Doctor of Counselling Psychology and Psychotherapy. The author is wholly responsible for the content and writing of the thesis and there are no conflicts of interest.

Abstract

The lived experience of depression is taken as a starting point for this research which aims to document and explore the variety of experiences of depression among a diverse sample of participants who have been diagnosed with and/or self-report as having had an experience or experiences of depression, either currently or in the past. Using Q-methodology and drawing on social constructionism and existential-phenomenology (particularly the work of Kenneth Gergen, Rom Harré and Martin Heidegger), I ask the questions 'How do participants experience (clinical and non-clinical/self-identified) depression? How do participants' experiences resemble or differ from established psychiatric and clinical psychology accounts of depression and how might the findings be relevant to existential counselling psychology practice? There were two phases to this empirical study. Firstly, a preliminary focus group study was conducted using a 'clinical' and a 'non-clinical' group and thematic analysis was used to analyse the data which provided information and materials for the development of the concourse of statements used in the main sorting task. Secondly, the main Q-methodological study required 46 participants to sort (online) a series of 58 experiential statements along a continuum 'most like me when I'm depressed' to 'least like me when I'm depressed.' Nine of these statements were based upon the current DSM-5 diagnostic criteria for major depression. Principal component's factor analysis produced eight interpretable factors which represent eight different (but shared) experiences of depression as follows; 1) 'Clinical'/suicidal depression, 2) The 'blues'/overcoming loss and bereavement, 3) Anxious/'anti-clinical' depression, 4) Emotionally devoid/isolated depression, 5) Sadness and loss/surviving depression, 6) Alienated/helpless depression, 7) The 'blues'/surviving through self-reliance, 8) Loss of meaning/depression as part of the cycle of life.

These different experiences are explicated in detail and in relation to the placement of the DSM diagnostic statements. Only one of the factors showed a strong similarity to the DSM criteria while all the other factors revealed experiences that may not be captured by those measures. The results are considered in relation to social constructionist critiques and existential-phenomenological philosophy. Finally, the relevance of the findings for existential-phenomenological counselling psychology practice is discussed.

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Chapter 1 Introduction

1.1 Introduction

The notion of ‘depression’ as an enduring sad, low, melancholic mood is one that has meaning not just at a personal level for those who have experienced it, including the families, friends and loved ones of those who are affected, but also in broader cultural terms - from its representation in art, music and literature through to the ways that science, especially via the knowledges and practices of medicine and psychiatry, has sought to map the truth of, and above all to document and treat the pathology of, this particular lived experience. This complex and multi-layered order through which depression has meaning for both clients and for professionals and practitioners has, for some time, been dominated by medical and psychiatric accounts, including those found within ‘Abnormal’ and Clinic psychology, which occupy a privileged place among the various representations with respect to their claims to truth. Here I advocate a different, alternative view and in this thesis I set out to take the lived experience of depression (or put another way, its phenomenology) as the starting point in the research and seek to explore a social constructionist and existential interpretation that is grounded in participants’ own accounts of what their depression is like. By exploring such a constructionist and existential-phenomenological understanding of depression I seek to offer some kind of constructive critique of accounts which, for me, take an overly narrow perspective in trying to understand the lived experience of depression. Moreover, I also seek to explore the experience of depression in a way that fits well with and informs a phenomenological approach to counselling psychology practice and to enable me to add my voice to those calling for the humanist/phenomenological value base that, for

many of us, defines counselling psychology as a distinctive practice/profession, to be upheld, promoted and defended within and without psychology.

Thus, the overall aim of this thesis is to, despite the seeming familiarity of the term, map some of the complexity and the rich variety of ways in which persons can experience that which we name depression, and to contribute to the development of an existential understanding of those experiences in a way that is not limited by or, indeed, overly dismissive of, clinical psychology and medical accounts - for example those found within the current version of the Diagnostic and Statistical Manual (DSM-5).

At this point I wish to say something about the way I intend to tackle this project and write this thesis. It is important to me that this thesis not only presents meaningful and useful empirical research but that it is presented in a way that is fully personal and reflexive. Following this, it is also important to me that this thesis takes a critical and questioning stance, not only towards the theory and practice of psychology and counselling psychology but also towards its own theoretical and methodological frameworks. Critical reflection has been central to my work as an academic over many years and my more recent work as a psychology practitioner. In particular, I see critical reflection as a deeply personal practice, it is something that arises very naturally for me and is a way of working that fits well with my personal ethics, my politics and my values, which I aim to explicitly include in my writing.

1.2 The background to the project

The research undertaken here came about as a development of my long-standing interest in the medicalisation and pathologisation[1] of human conduct and of what

[1] Meaning to regard or characterise persons, experiences and behaviours as medically or psychologically abnormal.

might be termed problems in living. This concern has a special resonance with current debates and controversies concerning the identity and philosophical basis for counselling psychology as a profession (see Woolfe, 2016). In particular, it connects with the current desire/concern that Counselling Psychology should or could become integrated or subsumed with Clinical Psychology (with its continued reliance upon mainstream psychological science and medical models of psychopathology) or a generic Applied Psychology (Anonymous, 2009; Gidding, 2009; Turpin, 2009). I have previously researched and written about discourse and power relations in psychotherapeutic practice, radio counselling and the overhearing audience, how the later 'ethical' work of Michel Foucault might contribute to an understanding of power relations in counselling theory and practice and the strengths and pitfalls of using psychoanalysis in counselling practice with sexual minority clients. All of these projects have involved a questioning and critiquing of what might be termed 'dominant discourses' and the relations of power, subordination and oppression that we so often take for granted and therefore fail to recognise. This current project enables me to further develop my interests in existential-phenomenological methodology and counselling psychology practice along with my earlier, long-standing interests in social constructionism, Q methodology and the potentially oppressive aspects of psychological discourse and practice (Hodges, 1998; 2002; 2007, 2011).

This project employs a broadly social constructionist theoretical and conceptual framework, in particular drawing on the work of Kenneth Gergen, Rom Harré and the post-structuralist work of Michel Foucault while adopting an existential-phenomenological approach to method and methodology, in particular drawing on the work of Martin Heidegger. It is important to note that while social

constructionism forms the overall conceptual backdrop to the thesis, the key aim is to explore the lived experience of depression through an existential-phenomenological lens. Also, bringing these two frameworks together necessitates an acknowledgement of the tensions, critiques and disagreements both within and between their respective theories and practices, which I discuss in Chapters 2 and 7.

The seeds of this current project were sown several years ago while I was an undergraduate student at the University of Reading during the late 1980s. My deep commitment to the utility and value of psychological theory and practice transformed during that period into a radical questioning of the discipline. Although I was initially enthralled by psychology and in particular by the idea of studying human beings, their thoughts, their feelings, their behaviour, I rapidly began to question much of what I was being taught. In particular, I felt uncomfortable with the kinds of reductionism and (over) generalisation that was presented as part of mainstream experimental psychology. I am very thankful that by my second year I discovered - through the great knowledge and inspirational teaching of one of my tutors, the late Rex Stainton-Rogers - an intellectual space and most importantly a whole new vocabulary for articulating my concerns and my doubts, especially with regard to what I felt to be the oppressive, or at lease potentially oppressive, aspects of mainstream psychological research and practice.

One key element of my personal growth at that time was my introduction to the social constructionist movement within psychology and what we now call Critical Psychology (see Fox, Prilleltensky and Austin, 2009). Rex Stainton Rogers, through his incisive, thoughtful and often very amusing lectures and seminars on a range of alternative perspectives (Critical Psychology did not exist as a sub-discipline then), showed me a new vocabulary which enabled me to gradually find my voice in

opposition to much of what I saw as problematic in psychological theory and practice at that time. In particular, although I had begun my degree with the keen intent to take up clinical psychology, by the end of my second year I had entirely changed my thinking. I began to see clinical psychology, especially as it was then, as a dividing, pathologising, and sometimes dehumanising practice. These days I do not feel quite as strongly as I once did, however I do feel that many of the concerns I had nearly 30 years ago are, regrettably, still valid today, although sometimes to a lesser degree.

Critical Psychology has gainfully occupied me from the time I began to develop my academic career in 1989 and ever since. This has not been an easy career path to follow not least because, although somewhat reduced now, there has been and there still remains hostility within the discipline towards the kinds of critiques and alternatives presented by Critical Psychologists. Despite this however, the sub discipline has been something that has enabled me to work as an academic in a way that has been personally more meaningful and authentic.

While social constructionism provided me with a key way in which to contextualise and meaningfully critique what I saw as problematic within the discipline, at the same time I was introduced, through Rex, to Q methodology as an alternative and potentially radical psychological method. I used Q methodology for my final year project looking at accounts and understandings of depression. That project was more an ‘attitudes’ and opinions piece rather than looking at the lived experience of depression itself - as I aim to do here. Looking back, my undergraduate project was, of course, tied up with my personal struggles, especially my struggle in the late 1980’s and early 1990’s regarding my sexual identity as a gay man and the profound sadness that I often felt throughout that period. I have a

strong memory of that time that has stayed with me. I am sitting in my room (in a Hall of Residence in Reading), alone and in the dark, feeling a deep and stultifying sadness and wondering how on earth I can carry on knowing that as a gay man my life is bound to be sad and miserable, perhaps even intolerable. That memory has stayed with me not only because those feelings were part of an often difficult and painful process of gradually coming to accept and then to value and appreciate myself, but also because, in my work both as an academic and a practitioner, I continue to hear similar stories from students and clients which reflect the enduring difficulties that sexual minority women and men face in coming out to themselves and others, even today. At the same time, 27 years on, I am grateful to have matured and developed, (mostly) made peace with that period and become much more comfortable in my own skin. Moreover, I have at the same time developed a deeper and more fully embodied understanding of my own sad moods and the ways these are part of who and what I am.

Aside from the formal aims of the thesis which I present shortly, my personal interest is to play a part in questioning and critiquing the pathologisation of depression and the over reliance on bio-medical accounts in Clinical and other areas of psychology, for example Abnormal Psychology. These issues link not only with debates concerning the philosophy and identity of the profession of Counselling Psychology but also with my own personal identity as a counselling psychologist. Thus, I see this thesis as an important means through which I can explore and further develop my own counselling practice, my sense of how I work with clients and what existential-phenomenological counselling psychology practice means to me. In the next part of this chapter I present a brief summary introduction of what is meant by the term depression, from a medical/clinical and then an existential perspective,

and go on to outline the aims and objectives of the research. I present the particular existential-phenomenological approach utilised in this thesis later on when I discuss methodology in Chapter 4.

1.3 What is depression?

The term ‘depression’ holds currency both as a psychiatric diagnosis or syndrome and also as a lay or ‘everyday’ expression. Feeling depressed is not only a common experience for many persons but also a phenomenon which is deeply embedded in Western cultures through art, literature, music, the media, popular and professional science and a wide range of other images and representations. The lay term depression is usually taken to mean a very sad mood, a state of mind determined by the negative prevailing emotions which commonly include sadness and melancholia, fear, anxiety, guilt, and often hopelessness and loneliness. More formal scientific/psychiatric definitions in the psychological literature refer to depression as an ‘affect disorder’ which when mild and relatively short lived is quite normal and fairly commonplace. However, where the depression is intense and longer term the sufferer may be diagnosed with ‘clinical’ depression which is viewed as a form of pathology or disease. In this sense depression, both ‘normal’ and pathological, ‘non-clinical’ and ‘clinical’, are seen as different manifestations of the same syndrome.

Diagnostically, depression is separated into several forms with two major categories - unipolar and bipolar - and with a variety of subtypes for each category. According to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013: 160), the criteria for diagnosing a major depressive episode are that ‘five (or more) of the following nine symptoms have been present during the same two-week period and represent a change from

previous functioning' and where 'at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure'. These nine criteria come under the label of 'criterion A' (American Psychiatric Association, 2013:160-161), I have exactly reproduced the criteria as follows:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feel sad, empty, hopeless) or observation made by others (e.g. appears tearful). (Note: in children and adolescents, can be irritable mood)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

In addition to the criteria above which form the first of three diagnostic categories, the patient must also fulfil the following two criteria:

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or to another medical condition

In contrast to the previous manual (DSMIV-TR), this more recent and updated version (DSM-5) now includes several new depressive disorders, for example

‘disruptive mood dysregulation disorder’ (for children up to 18) and ‘premenstrual dysphoric disorder’. The disorder of ‘dysthymia’ found in DSMIV-TR has been replaced with ‘persistent depressive disorder’ which also includes the previous ‘chronic major depressive disorder’. Several new specifiers have been added in DSM-5 including ‘anxious distress’ and ‘with mixed features’ which specify the role of anxiety and bipolar symptoms in major depression respectively (APA, 2013). One crucial stated element of the scientific basis for these disorders are the biological and neurological correlates relating to the medical phenomenology, however these correlates do not amount to a causal link which would enable prediction, as stated in the DSM-5 (American Psychiatric Association, 2013:160-161):

> Although an extensive literature exists describing neuroanatomical, neuroendocrinological, and neurophysiological correlates of major depressive disorder, no laboratory test has yielded results of sufficient sensitivity and specificity to be used as a diagnostic tool for this disorder.

These diagnostic criteria for major depressive disorder give a sense of the ways in which the means of identification (and the subsequent treatment) of depression are presented and codified. Here there is a very strong emphasis on nosology, that is on the detailed classification of the different types and forms of the disease. There has been much critical reflection on the DSM itself, including the changes and additions to the new edition with respect to depressive disorders (see for example, Pickersgill, 2014; Bandini, 2015; Horwitz, 2015), and while much can and has been said about the limits of the medical model in general as a means through which to understand problems in living, my focus in this thesis is specifically upon the medicalisation and pathologisation of sadness and unhappiness, and the extent to which we should embrace or resist this in counselling psychology.

An alternative, existential perspective would suggest that we are thrown (Heidegger, 1962) into a world of social, cultural, moral and political representations and understandings (carried through language and discourse) which has already been constructed. Thus, a significant element of our 'reality' is defined for us in the form of the language(s) we learn and all that comes with them, for example concepts, categories, morals, cultural ideals and so on. In this way, much of the sense we make of the world - and the way we experience it - is both enabled and constrained by language and linguistic structures. Given this, it is important to note the role of the language deployed in the list cited above where the feelings and behaviours described are constructed as symptoms of an underlying condition or disease – and given various specific names, for example Major Depressive Disorder, Disruptive Mood Dysregulation Disorder, Persistent Depressive Disorder and Premenstrual Dysphoric Disorder - all of which revolve around the central image of a depressed mood. Dorothy Rowe has argued that in Indo-European languages the basic sentence structure requires a subject and predicate, so that when we observe certain activities and give them a name, for example calling the above listed actions and experiences 'depression' and then place the word within a sentence, we begin to see it as something tangible and material. Rowe (1988:19) provides a useful example of this process of reification using the common cold:

> We see a friend coughing, sneezing and blowing his nose. We observe all these activities, lump them together and give them a name, 'a cold'. Then we put 'a cold' in a sentence and immediately start to treat it as a real thing. 'I see you have a cold' we say. 'Don't give your cold to me' as if we can hand round a cold in the same way we hand round a plate of cakes.

In the same way, the term or category of 'depression', may to some extent reify[2] a complex and fluid individual experience, especially when that experience is understood in terms of a comprehensive nosology. While the categorisation which results from such nosological practice may, in a positive way, help us to make sense of this experience, to make something strange and possibly alien seem more familiar, the received and available medical and clinical constructions may also misrepresent or even distort our lived experience. Here I argue that these kinds of medicalised/nosological representations have a strong tendency to objectify both the person/client with depression and their lived experience. Moreover, when Clinical and other psychologists diagnose their patients as having depression, it is assumed that the diagnosis more or less accurately identifies the patient's experience - but even where the patient agrees or is questioned in detail about their depression, how can we know that the patient's and the psychologist's understanding of the condition are congruent? In that vein, Horwitz and Wakefield (2007) argue that the DSM diagnostic criteria for depression have led to more and more false positive diagnoses:

> [I]n the change of context from the clinic to the community, the false positives problem latent in the DSM criteria emerged with a vengeance; in fact the new epidemiological instruments equally identified both pathological depression and widespread intense normal sadness… and thus they grossly overestimated the number of depressive disorders in the untreated population. (p. 124)

In contrast to the medical (clinical), nosological approach described above, the phenomenological method employed in this thesis enables a primary focus on participants' lived experience - which includes the bracketing off (I return to this

[2] Meaning to understand or represent something non-concrete or conceptual as a real and concrete thing. Here this refers to reducing or labelling the complexity and fluidity of moment to moment lived experience in a way that distorts or negates it.

concept in Chapter 4) of theories and models such as those described in DSM-5. Thus, a central theme in this thesis is that of placing participants' own experiences, their own voices, at the heart of the research. This central role of participants' lived experience I argue, goes some way towards making up for what can be described as a loss of the experiencing, embodied, choosing agent in social constructionism and post-structuralism (I discuss this in the following chapter and I later argue for the utility of existential-phenomenology in this regard). Furthermore, for me, phenomenology offers a means of focusing on the lived, experienced world without recourse to the psychologisation and individualisation which often accompanies psychiatric and clinical/abnormal psychological accounts.

1.4 Research aims and objectives

In this research I aim to uncover the complexity and variety of participants' experiences through the use of a Q-methodological approach in which the participants' voices can be clearly and fully heard. My key objective is to document and explore the variety of experiences of depression among participants who have been diagnosed and/or self-report as having had an experience or experiences of depression, either currently or in the past. Thus, my definition of the term depression here relies upon participants' self-identification and self-definition in addition to self-reported diagnoses and therefore includes what has been termed 'clinical' and 'non-clinical' depression in order not to limit the phenomena which might be identified under this term or category. I aim to explore the experience of depression in a way that better preserves the phenomenon, especially the complex and varied ways in which depression can be experienced. Thus, I operate here with a very general and open understanding of depression - as opposed to a narrower clinical one - in order to uncover the variety of experiences that may be related by this term and to get

closer to the 'thing itself'. In this way I aim to, in some way, challenge the pathologisation of depression and to usefully map the variety of experiences that may be subsumed under this term or category.

In addition, I wish to explore what emerges when we analyse personal experiences of depression through social constructionist and existential-phenomenological lenses and how this may inform existential-phenomenological counselling psychology practice. Using Q-methodology as a phenomenological tool, I ask the questions 'How do participants experience (clinical and non-clinical/self-identified) depression? How do participants' experiences resemble or differ from established psychiatric and clinical psychology accounts of depression and how might the findings be relevant to existential counselling psychology practice? Thus, the findings will be analysed in relation to existential-phenomenological theory and therapeutic practice, and especially through some of the ideas of Martin Heidegger.

There is one final reflection I wish to give in this chapter. While I am arguing that some representations or versions of depression, especially the medical and 'clinical' accounts, in some sense objectify[3] and reify the lived experience, it could also be argued that this research risks doing the very thing that I'm critiquing; reifying and potentially objectifying the lived experience depicted in the study. My feeling with regard to this issue is that as soon as there is reflection on immediate, pre-reflective experience it becomes another type of lived experience; for example, a reflective, thoughtful type of accounting and sense-making. Indeed, for me, it is almost impossible to capture pre-reflective experience given that as soon as we share or communicate that experience, including reflecting on and communicating it to

[3] Meaning to treat a person as if they were an object, or put another way, to fail to recognise and to treat a person as a complex, feeling, experiencing human being.

ourselves, we - intentionally and/or unintentionally - bring in forms of interpretation and sense-making which inevitably display and mirror social and cultural as well as individual and personal structures and processes. The boundary between the description of immediate experience and interpretation/sense-making is an extremely narrow one which is very difficult to realistically identify. It may be that pre-reflective experience is itself always already permeated and suffused with discourses, images and representations which we have already internalised and inhabited. With regard to this thesis I argue that reification and objectification can, to some extent, be avoided by grounding the project in the lived experience of participants, by placing lived experience at the heart of the work; something Q-methodology is ideally suited for. Furthermore, reification does not inevitably result in pathologisation, rather there are other process which play a role, for example the complex relations of discourse, practice, power and authority. These and other issues are discussed in later chapters.

1.5 Summary of chapters

Following this introduction, in Chapter 2 I present the conceptual framework of the thesis through a personal exploration and discussion of the social constructionist movement in psychology, including post-structuralist and other critiques along with the role that phenomenology could play in potentially enhancing these frameworks. In Chapter 3 I review and discuss selected relevant research literature with a focus on historical, autobiographical and clinical/abnormal psychological accounts of depression. Chapter 4 is split into two parts, firstly I present an account of the phenomenological methodology used in this thesis, briefly describing the overall phenomenological movement and then focusing on the work of Martin Heidegger. Secondly, I describe the methods used in the thesis. I then present the results of the

preliminary focus group study in Chapter 5 and the results of the main Q-methodological study in Chapter 6. Finally, in Chapter 7 I discuss the overall findings and their relevance for existential-phenomenological counselling psychology practice.

Chapter 2 The conceptual framework of the thesis: Social constructionism

2.1 Introduction

In this chapter I describe the social constructionist conceptual framework as it forms the backdrop to this research project. I outline some of the key ideas and debates to be found within social constructionism and go on to discuss some key critiques of the movement, especially those made in relation to its major focus on the role of language in the social construction of reality. I then describe how post-structuralist ideas, especially the work of Michel Foucault, can address some of the shortfalls identified concerning the constructionist perspective and finally I present an argument for phenomenology as one key means to enhance social constructionist thinking, especially with regard to phenomenology's focus on the embodied and relational aspects of lived experience. Given the reflexive nature of this thesis I have structured this chapter in a way that directly reflects my own personal journey through these ways of thinking about and critiquing psychology. I begin with the early development of social constructionism within psychology during the 1970's and 1980's, then move on to more recent debates and contributions to the field including work on the social construction of emotion and mood.

I was introduced to social constructionism several years ago while I was an undergraduate psychology student (in the late 1980's) and I went on to develop my own connection to those ideas, in particular through the work of Michel Foucault, while I was a postgraduate working on my Doctoral thesis (Hodges, 1998). My shift towards the writings of Foucault came about largely as a result of the inspiration of Nikolas Rose, my supervisor. For me now, social constructionism still offers a theoretically sophisticated critique of, and at the same time alternative conceptual

and methodological approach to, psychological theorising and practice. I still believe that the challenges and critiques found within social constructionism enable us to rethink and reconstruct mainstream psychological theory and practice in a way that places clients' own experience at the heart of psychological practice. For me, these ideas, in providing a more culturally sensitive and contextualised, and above all a less objectifying understanding of emotions including depression, are especially useful for the development of effective counselling psychology practices.

2.2 Social constructionism and its relevance for Psychology

Social constructionism is a term that encompasses several different perspectives, different ways of thinking about human beings and the ways they interact, and especially different critiques of scientific and positivist approaches in the social and human sciences. I suggest that there are at least four key areas of critique to be found within constructionist ideas. Firstly, the social constructionist approach, in line with other (broadly) post-modernist critiques, dismantles modernist ideas of truth and in particular the notion that there is a real, true, discernible world 'out there' which we can access directly through the senses (the fundamental pretext of empiricism) and which pre-exists our interpretation and our sense making. This problematisation of truth and fact offers a means of questioning and sometimes resisting the kinds of methodology that psychology has borrowed from the natural sciences. Furthermore, it enables us to deconstruct notions of objectivity while at the same time bringing to the fore the social, historical, economic, political, moral and cultural structures and processes that in complex ways entail the conditions of possibility for that which we take to be true and real – such that truth becomes an effect of those processes. This, roughly speaking, moves us away from the realism of much of mainstream psychology, including some of the more scientific elements of counselling

psychology, towards the relativism of post-modern thought. In this way, a realist (and, for some naïve) notion of truth is avoided in favour of the notion of multiple truths and thus the focus shifts away from finding *the* truth towards the analysis and scrutiny of different and/or competing claims to the truth, including individual, subjective truth. Through this way of understanding ourselves and the world we inhabit, truth is considered as itself a representation. Furthermore, in this account the very notion of truth, and I will return to this issue later in this section, is bound up in complex ways with the processes and effects of power and regulation (see especially Foucault and Faubion, 2002). It should also be added here that Martin Heidegger (2002) proposes a very different way of understand truth which he refers to as 'aletheia', as a presence of Being that equates to some kind of original understanding and which itself precedes our representations and accounts, I discuss this in more detail in Chapter 4, part 1.

Secondly, social constructionism offers a profound challenge to the dominance of a representational theory of language within mainstream psychology. For social constructionists, language is not only representational, that is providing labels with which to index and describe what we take to be a pre-existing reality (which often corresponds to our own experience of using words), it is also constructive and performative. In other words, language does not only enable us to represent ourselves, others and the world around us, it also plays a key part in constructing that world, in making certain kinds of representations and interpretations possible (through constructing what we take to be real and true) while at the same time limiting the ways in which we can make sense of ourselves, others and the world around us. Moreover, for Austin (1975), the originator of Speech Act Theory, language also performs certain kinds of actions, for example promising, inviting,

greeting, complaining, requesting, ordering and so on. Adopting this more complex theory of language not only points to the limits of mainstream psychology in this regard, but also suggests an approach to psychology (and counselling psychology) that is much more qualitative; focused upon language use, accounts, interpretations and what has been termed the 'action orientation' of language, in place of the usual focus on cognition (see, for example Edwards, 1996; Te Molder and Potter, 2005).

Thirdly, social constructionism challenges what some see as the individualism of psychology, the ways in which a particularly Western notion of a unique, fully contained and bounded individual has operated at the heart of the discipline and as its main object/target. One challenge to individualism from social constructionism is the problematisation of the ways in which psychology has tended to locate problems, issues, difficulties and especially thought and lived experience, entirely *within* persons and, for some commentators (see especially Sampson, 1989; 2008), in so doing, has played a key role in pathologising those individuals who are perceived in some sense to be outside of that which is constructed as normal. Put another way, the individualism of mainstream psychology plays a role in *fixing* problems and issues firmly within certain individuals and groups, but where those problems and issues may in fact have their origin in the relational world and/or in society and culture itself. This is something I return to later in this chapter.

Finally, social constructionism offers a challenge to the essentialism of mainstream psychology. Much of mainstream psychology comes from an essentialist position - that is where there is some assumed underlying quality that defines ontological status - and its explanations are often essentialist in nature, for example positing neurological, genetic, hormonal and cognitive structures and processes as foundations of behaviour and conduct. Psychology as a discipline in some ways

exists in between the social and the natural sciences, however for some, the most authoritative aspects of the discipline are those which correspond closely to the methods of the natural sciences. Indeed, some commentators of the history of the development of quantitative methods in psychology (Rose, 1985; 1999; Danziger, 2010), have argued that, early on, psychology as a discipline had to borrow from the natural sciences in order for its truth claims - both within and without academia - to be accepted both as authoritative and as a sound basis for a valid new discipline. Most importantly, as I have mentioned, for social constructionists, essentialism has a political aspect to it in that such explanations tend to fix characteristics, issues and problems within persons while simultaneously eschewing explanations that move beyond the individual, for example those focusing on social and economic structures. Thus, for many constructionists, essentialism too easily lends itself to oppressive, unjust knowledges and practices (for a useful example see Butler, 1988). My own academic and personal journey has very much been about challenging inequality and oppression and social constructionism has provided me with a powerful and useful framework for my continued growth and development as an academic and as a counselling psychologist.

2.3 The development of social constructionism in Psychology

In this section I further explicate the social constructionist perspective by considering its impact in Psychology and its contribution to reshaping some aspects of the discipline. Social constructionism has made a very significant contribution to critiques of mainstream psychology and played a key role with regard to an earlier phase of critiques within psychology during the 1970s and 1980s, providing new, and at that time radical, ways to rethink the key aims of the discipline. One important moment during this earlier phase occurred with the publication of Kenneth Gergen's (1973)

paper Social Psychology as History. In that paper Gergen argued that rather than borrow methodology and methods from the natural sciences, what we do in social psychology much more closely resembles a form of historical enquiry.

In this seminal paper Gergen (1973) offered two main arguments, firstly that the subject matter of psychology differs profoundly from that of the natural sciences in that psychological knowledge and practice can have profound effects on the very subject of inquiry; the ways people think and feel and the ongoing ways they interact with and relate to each other. (Gergen, 1973: 310) argues that 'psychological principles… [may] sensitise one to influences acting on him [or her] and draw attention to certain aspects of the environment and him [or her]self' This proved a very powerful argument for some in psychology, reminding us that we need to take great care in assuming that there are 'natural' trans-historical laws of human behaviour and experience and that the knowledge we produce as psychologists, in complex ways, can become part of the overall stock of human knowledge. In this way Gergen (op cit: 310) suggests that '…knowledge cannot accumulate in the usual scientific sense because such knowledge does not generally transcend its historical boundaries.'

Secondly, Gergen argued that what we observe in psychology, even that which appears to be stable and consistent, is always historically contingent. He cites many examples where earlier theorising has become outmoded and outdated because of changes over time. In Gergen's words (op cit: 316-317):

> We are essentially engaged in a systematic account of contemporary affairs. We utilise scientific methodology, but the results are not scientific principles in the traditional sense. In the future, historians may look back to such accounts to achieve a better understanding of life in the present era. However, the psychologists of the future are likely to find little value in contemporary knowledge.

Gergen further argued that (1970's) psychology had very few tools available to enable a proper understanding of the interrelation of experiences and events over longer periods of time. For him our object of study as psychologists *is* history in that those objects and subjects that we study are in constant flux, constantly shifting and changing, in part in response to psychological knowledge and practice. Given these two key problems with mainstream psychology, particularly as it was during the 1970s, Gergen concluded that '…[T]he continued attempt to build general laws of social behaviour seems misdirected, and the associated belief that knowledge of social interaction can be accumulated in a manner similar to the natural sciences appears unjustified.' (op cit: 316).

Gergen further develops these ideas in his widely cited 1985 paper The Social Constructionist Movement in Modern Psychology. It is this paper that first drew me into social constructionism and then towards critical psychology while I was an undergraduate. I was a fierce and passionate recruit. By the time this (1985) paper was published both Gergen and the discipline itself had changed in response to the different critiques which were growing in popularity at that time. In this sense, it is interesting to see the ways in which Gergen's ideas have changed in this paper twelve years after his critique based on the notion of psychology as history. At this point Gergen summarised the social constructionist endeavour as follows:

> Social constructionist enquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed. (Gergen, 1985: 266).

In this paper, Gergen offered a means to develop an alternative metatheory that enables psychology to move beyond the limits of empiricism and rationalism, where the social epistemology of psychology's object(s) of study comes to the fore. The notion that language is a carrier of truth is profoundly questioned here. In this new relativist version of psychological endeavour, psychology itself must be understood as a social process and the discourses, descriptions, interpretations, images and metaphors utilised by both ourselves and the persons/clients we study/work with become central to the discipline. For Gergen this meant that our discipline in a sense needed to move closer to something in between the disciplines of psychology and sociology, however at this time, another related philosophical and conceptual framework was beginning to have an impact on both these disciplines; post-modernism.

2.4 Social constructionism and post-modernism

As post-modernism gradually found its way into psychology from the 1980s onwards, Gergen and others (for example Kvale, 1992; Holzman and Morss, 2000) saw the important links with social constructionism. In his 2001 paper Psychological Science and a Post-Modern Context, Gergen further developed his critique of mainstream psychology in line with post-modern critiques outside of the discipline. He notes that there are three key areas where post-modernism might help us to revise and develop psychology in a more meaningful way that is relevant to our contemporary present. Firstly, he suggested post-modernist arguments enable us to question the centrality of individual reason in mainstream psychology. Thus, the modernist emphasis on individual rationality has, according to post-modernism, in fact produced hierarchies of rationality where some individuals and groups are placed outside the rational, outside of full reason. Furthermore, rationality itself for Gergen

and others is rhetorically constituted. One form of rationality can no longer be seen as superior to other forms, rather we need to be much more relativist in this regard. Ultimately for Gergen (2001: 807-808) '… the exercise of rationality is … an exercise in language… Making sense - or being rational - is inherently a form of communal participation.' Therefore, rather than understanding rationality as a product of the natural world it must be understood as itself a social and historical construction, or in Gergen's view a form of epistemology. Related to this, Michel Foucault's earlier work, for example in Madness and Civilisation (Foucault, 2006), sought to map the historical construction of reason and unreason from the Middle Ages onwards and I will return to Foucault's key contribution to these debates a little later.

Secondly, Gergen questions the notion of a directly observable world readily available to us in a form which is unsullied by social psychological and cultural structures and processes. From a Post-modern perspective the world is never simply 'out there' waiting for us to observe and to make sense of it in some kind of direct and straightforward way. Rather, what we take to be true and what we take to be real are themselves social constructions, fundamentally tied to discursive and linguistic practices. Moreover those discursive practices must themselves be understood within a wider historical, social and political context. In Gergen's (2001: 808) words, '… What we take to be "the real", what we believe to be transparently true about human functioning, is a by-product of communal construction'. In this paper Gergen is at pains to remind us that this is not an idealist argument, rather post-modernism requires us to understand the ways in which our experience and understanding of 'truth' and 'reality' are always necessarily bound up with that which we bring to bear upon them, how ways of describing what exists must always arise from shared, communal understandings and intelligibilities, which are, in turn, bound by their

historical, social and cultural context. Here again the work of Michel Foucault is relevant and I will return to this a little later in this chapter.

Thirdly, Gergen reminds us of the centrality of language itself in post-modernist thought. Here language is not only, or merely, a means to represent the world, to label it, but it is also fundamentally implicated in the social construction of what we take to be real, what we take to be true. It is to language that we need to look if we are to understand the 'real', if we are to properly understand the nature of science. For Gergen (2001: 809):

> … Language is world constituting; it assists in generating and/or sustaining certain forms of cultural practice… Science is not to hold a mirror to nature, but to participate actively in interpretive conventions and practices of a particular culture.

Gergen's version of social constructionism is one that was widely welcomed by psychologists who wished to be critical of the mainstream elements of the discipline, however Gergen's emphasis on the negotiated, interactional, communal process of social construction (see Gergen, 2009) brought various critiques from within and without the developing Critical Psychology community. These critiques focused on the need to move beyond the key role of linguistic structures towards other kinds of non-linguistic structures and practices including the operation of power. Indeed, my own struggle with the shortfalls of social constructionism led me towards a deeper engagement with post-structuralist ideas and especially the work of Michel Foucault. For myself, while I was greatly attracted to Gergen's work and ideas, not least because he was so active in bringing new ways of thinking and understanding into psychology in a way that made sense to many of us who were searching for a means to critique and to question the mainstream, I struggled with what I saw as too limited an understanding of the broader historical and cultural

context of language use. These limitations are especially relevant when trying to understand the psychology of emotions and therefore, before I address the limits of social constructionism, I wish to outline another important strand in the social constructionist movement that has particular salience for the study of depression; studies and debates concerning the social construction of emotion and mood.

2.5 The social construction of emotions

An influential text appeared in 1986 edited by Rom Harré called The Social Construction of Emotions. This text usefully demonstrates the relevance and utility of this approach for understanding feelings and mood, including depression. This work focused on the ways in which the individual, lived experience of emotions can only be fully understood with reference to the social, linguistic and historical context. At the start of the book Harré lays out his version of the social constructionist viewpoint concerning emotions and some of that account is useful here. Harré reminds us that much of psychology up until that time (and I would argue that the discipline, to a large extent, continues in this vein) placed a representational theory of language at the heart of its endeavours. In relation to the study of emotions he suggests:

> Psychologists have always had to struggle against a persistent illusion that in such studies as those of the emotions there is something *there*, the emotion, of which the emotion word is a mere representation. This ontological illusion, that there is an abstract and detachable "it" upon which research can be directed, probably lies behind the ineffectiveness of much emotion research. (Harré, 1986: 4).

Harré suggests that the 'it' that underlies emotions is primarily some form of physiological state which forms the ground for what he terms 'felt perturbation' (op cit: 4) and that psychologists, falling into the trap of the ontological illusion, have often made the assumption that the physiological state and the emotion are the same thing. Instead, for Harré the experience of emotion is shaped and indeed

limited by the linguistic resources available to us, that is we draw upon what he terms ‘repertoire[s] of social practices’ (p4) which are themselves one condition of possibility for feeling a particular emotion or mood in the first place. Above all Harré argued for the re-contextualisation of felt emotion such that the social, cultural (and ultimately historical) processes and practices that make up those repertoires can be made more visible, and this in turn can enable us to more fully and deeply analyse and understand the lived experience and personal meaning of felt emotion. In Harré’s words:

> There has been a tendency among both philosophers and psychologists to abstract an entity - call it anger, love, grief or anxiety - and then try to study it. But what there is are angry people, upsetting scenes, sentimental episodes, grieving families and funerals, anxious parents pacing at midnight, and so on. There is a concrete world of contexts and activities. We reify and abstract from that concreteness at our peril. (Harré ,1986: 4)

For me, this text usefully illustrates the way in which social constructionism invites us to question and sometimes to reject the individualising tendencies of mainstream psychology in favour of a much more contextually sensitive and therefore ‘ecologically’ valid approach. I would also argue that this approach allows us to get much closer to the tangible lived experience of human beings – who, as Heidegger (1962) reminds us, are never only individuals; we are never an ‘I’ on our own.

The various chapters of Harré’s edited text clearly illustrate the ways in which the phenomena that we label as emotions and moods are not only to be understood in terms of individual lived experience but also, and just as importantly, as fundamentally related and bound to their social, linguistic and historical context. In this regard, in a later chapter, Harré and Finlay-Jones (1986) discuss the decline and eventual disappearance of an important but now obsolete Medieval emotion called

‘accidie’ which, within our current vocabulary, would be defined as mental or spiritual sloth and apathy. This emotion manifested itself as *ostiositas* (idleness), *pigritia* (laziness) and *negligentia* (negligence), which in turn led to feelings of *taedium* (boredom with life), *tristitia* (sadness, sorrow) and *desperatio* (hopelessness, despair). There was an important link with religious duty here and Harré and Finlay-Jones state that the term *accidie* first appears in the works of Evagrius (AD 345-399, see Casiday, 2006) as ‘“the noonday Demon” which distracts a hermit from the duties of the ascetic life’ (op cit: 221). Harré and Finlay-Jones go on to describe the complex ways in which this emotion was embedded in the moral order of that time. So, for example, this emotion was linked to a kind of negligence and to feeling a kind of misery, where an association between misery and laziness resulted in particular kinds of prescription and proscription, in the words of the authors (op cit: 221):

> In so far as it [*accidie*] involved a failure to carry on with a tiresome, uncomfortable or boring task, the cultivation of fortitude formed part of its remedy. But dutiful behaviour without joy (*gauduim*) was an inadequate response. *Acedia* was truly overcome only when delight in the exercise of one’s proper activities returned.

Thus, *Accidie* provides a useful illustration of the pitfalls of apprehending lived experience (here in relation to felt emotion), in solely individualistic terms. Thus, I argue here that properly understanding depression requires an approach that is able to get beneath and also beyond the individual experience. *Accidie* also has historical connections to melancholia which I discuss in the following chapter.

This particular text had a profound impact on my thinking earlier in my career and, for me, it still provides many compelling practical illustrations of the ways in which social and linguistic practices and structures both enable, and at the same time, limit our individual lived experience. In the next section, I discuss some

shortfalls of social constructionism with reference to some key critiques of the movement.

2.6 The limits of social constructionism

As I suggested at the beginning of this chapter, the incorporation of social constructionism into psychology enables both a powerful critique of the realism, individualism, and the resultant psychologism of mainstream psychology and at the same time offers new theoretical frameworks and new methodologies through which to move the discipline forward. However, following its incorporation into critical and other aspects of psychology many theorists and commentators came to identify some of the shortfalls and limitations of social constructionism as it relates to the discipline of psychology (for example Parker, 1998, 2007; Cromby and Nightingale, 1999; Burr, 2015). Perhaps the most important of which, for this commentary, relates to what, for some, was an overemphasis on the centrality of language and the linguistic realm.

Hacking (1999), in his much discussed text ‘the social construction of what?’, takes issue in a detailed, philosophical way, with the significant expansion of constructionist work in the social sciences and what he sees as an unhelpful lack of rigour with regard to a proper conceptualisation of what it is we believe to be ‘constructed’. He argues that if we look closely at the wider body of work purporting to offer a social constructionist analysis it becomes evident that several different kinds and categories of things, objects and ideas are all, one way or another, represented in this body of work. He invites us to think more carefully about the question of what exactly we are claiming as socially constructed. Hacking then goes on to argue that social constructionist work is better understood as relating to a

range of elements including ideas, material ‘things’ and persons operating in complex interaction constituting what he terms a ‘matrix’, which for him equates to a much broader social setting than is often found in social constructionist work. He defines this matrix as follows in relation to the example of the social construction of women refugees (Hacking, 1999:10):

> …as a complex of institutions, advocates, newspaper articles, lawyers, court decisions, immigration proceedings. Not to mention the material infrastructure, barriers, passports, uniforms, counters at airports, detention centres, courthouses, holiday camps for refugee children. You may want to call these social because their meanings are what matter to us, but they are material, and in their sheer materiality make substantial differences to people.

Hacking’s argument appears to draw upon a Foucauldian conception of discourse as always already tied to concrete and material practice(s). Foucault was interested in the ways in which relations of power were to be found in heterogeneous systems and practices which for him included the complexity of the connections between discourse, practices, institutions, architectural forms, moral systems, economic relations and so on. In this way, Foucault’s understanding of the importance of language and discourse was always conceptualised as a part of wider apparatuses which Foucault calls *dispositifs*. Foucault (1980:196) describes the *dispositif* (apparatus) as follows:

> ...the apparatus is essentially of a strategic nature, which means assuming that it is a matter of a certain manipulation of relations of forces, either developing them in a particular direction, blocking them, stabilising them, utilising them etc. The apparatus is thus always inscribed in a play of power, but it is also always linked to certain co-ordinates of knowledge which issue from it, but, to an equal degree, condition it. This is what the apparatus consists in: strategies of relations of forces supporting, and supported by, types of knowledge.

Thus, for Foucault the *dispositif* is fundamentally tied to power and knowledge, which is defined in terms of the strategic relations of force that can be

found in our contemporary societies. What is important here is the way that language and discourse form only one element of a much more complex and heterogeneous apparatus which, in turn, forms the conditions of possibility for us to have certain kinds of knowledge, certain kinds of experience at all. For me, in this way both Foucault and Hacking provide a broader, more textured and heterogeneous account of the place and role of language and discourse (and history) in the social construction of reality. While I am not arguing in this thesis that a study of the lived experience of depression must necessarily include a detailed analysis of the broader structures and apparatuses that surround it, I do wish to argue that such an analysis should not constitute the lived experience as solely some kind of origin or foundation but rather should take into account the broader context and enabling conditions for that experience, which might include some of the structures and processes that Heidegger presented in his thinking about Dasein and I discuss this in more detail in Chapter 4, part 1. I now turn in more detail to the work of Michel Foucault in order to further conceptualise the role of discourse in the social construction of reality.

2.7 A Foucauldian perspective

For me, Foucault's conceptualisation of discourse as something always already bound up with relations of power and ultimately with history itself, provides a means to move beyond social constructionism's prime focus on the communal, on the space in between people (Gergen, 1985; 2001). A Foucauldian version of discourse acknowledges the ways in which not only individuals but also the ways they relate to one another, are to some extent constituted, made possible but also limited by the prevailing 'systems of thought' of any particular historical period, including our contemporary present.

Thus, while I personally sign up to many of the ideas found in the social constructionist movement in Psychology, and also have some sympathy with the critical realist stance, I turn to the work of Michel Foucault in order to move beyond the predominance of language, of linguistic structures in these critiques but in a way that, I believe, does not get caught up in the dualism of realism versus relativism. As I have already indicated, a key problem that I struggled with for some time, was how we can understand the context of lived experience in such a way that moves beyond the linguistic realm, moves beyond the 'text'. Put another way, how can we address the question; what is the place of the extra-discursive in social constructionism?

With Foucault's work it is important to properly understand the way in which he defines discourse - which is so central to each of his projects - as his understanding is somewhat different to others who have written about this topic. For Foucault discourse always refers to what we might call language-in-use, to language as it is spoken, read, created, utilised, interpreted and so on. Furthermore, language is always situated - for example in relation to culture, society, history, geographical location, moral order, economic relations, institutions and so on. Thus, for Foucault, language is never language on its own but rather is always already bound up not only with the wider context I've just mentioned but also with concrete practices, for example the ways in which language-use forms a key part of our practices as counselling psychologists and psychotherapists. However, Foucault goes further than this in that, for him, discourse, especially what Foucault terms dominant discourses, are also bound up with relations of power. Indeed, Foucault offers a novel way of understanding power as it operates in contemporary societies and cultures which I will now briefly describe.

For Foucault then, truth is not a matter of something that pre-exists or stands outside language and discourse, neither is it something that can be discovered through science and empiricism, rather he was interested in those things that we *take* to be true which for him come into being through relations of power and knowledge that at the same time are socially and historically contingent. When he was asked during an interview whether he thought that what he wrote was the truth, he famously replied:

> As to the problem of fiction, it seems to me to be a very important one; I am well aware that I have never written anything but fictions. I do not mean to say however, that the truth is therefore absent. It seems to me that the possibility exists for *fiction to function in truth*, for a fictional discourse to induce effects of truth [my italics]. (Foucault, 1980; 193)

For Foucault truth was always bound up with so much more than facts and/or what we might term 'reality'. Here truth is replaced by the notion of verisimilitude which is real in the sense that what we take to be true has concrete, material consequences. Put another way, for Foucault history places certain things on what he calls a 'register of truth' and he set himself the task of analysing and elucidating the ways in which particular systems of thought come into being during different historical periods, and the ways particular systems of thought come to dominate and to subjugate other ways of thinking and knowing. In this vein, the psychiatric, nosological accounts found in clinical, abnormal and other areas of psychology could be identified as contemporary dominant discourses.

However, from a social constructionist perspective we would expect that multiple 'repertoire[s] of social practices' (Harré, op cit: 4) would exist from which individuals could draw in making sense of their experience of profound sadness, along with multiple (personal) 'truths' in relation to what depression is/feels like.

As I have developed as an academic I have become less concerned with the issues of idealism versus materialism and realism versus relativism and much more concerned with a focus upon the question of how we can properly and meaningfully account for lived experience in a way that does not fall into the trap of psychologism or individualism, and this is what led me towards phenomenology as a way to describe and to elucidate the lived experience of depression.

2.8 A return to phenomenology

As social constructionism became a key part of critical movements within psychology it also became clear to many academics and practitioners that while social constructionism had enabled real and useful progress for the discipline, in eschewing individualism and psychologism we risked, to a greater or lesser extent, losing the experiencing agent. Put another way, with the new and useful focus on the notion of the person as an effect of discourse, or better as, in part, constituted through a multiplicity of discursive practices, we found ourselves less able to properly and meaningfully account for the lived experience of persons, especially their felt emotions and their motivations.

For some critical psychologists this problem of agency leads us back to the work of existential-phenomenologists. For example, Burr (1999) argues that although the constructionist theory of language posited within social constructionism is extremely useful and important for contemporary psychology, the role of embodied lived experience is in danger of being lost altogether. Burr argues that (1999:113):

> ... largely owing to constructionism's focus upon language as the primary constructive force behind social and psychological phenomena, the person as an experiencing subject has been exorcised from our understanding of human life.

For Burr, social constructionism needs to place much more emphasis on personal agency and choice and she suggests that the work of Merleau-Ponty provides a useful framework in this regard, in particular, Merleau-Ponty's understanding of the body as the foundation of lived experience. In this way Burr (op cit) argues for much greater inclusion of the extra-discursive, embodied aspects of personal experience. Likewise, Butt (1999) argues for the central importance of (pre-reflective) personal experience and embodied perception for a revitalised social constructionism. Butt focuses particularly on Merleau-Ponty's critique of dualism, individualism and empiricism and suggests that phenomenology provides a useful means to conceptualise lived experience in a way that is compatible with the tenets of constructionism. In this way Butt argues against what he sees as constructionism's assumptions that people use emotions in a similar way that they use language, following the rules of their operation. Instead Butt asks us to incorporate - via phenomenology - what Merleau-Ponty (2013) called the 'lived world' as a means of understanding and explaining personal experience in a way that does not return us to the dualisms of traditional psychology. As Butt (1999: 137) suggests:

> …our emotional engagement is not just made in language; it is a reality that is constructed between the person and his or her world. This engagement is often ambiguous, and our feelings are often ambivalent. They cannot be reduced to simple description of what we really want, or feel. There is no internal meter to be read, as the realist would have us believe.' (Butt, 1999: 138)

This focus on the relation between the person and her or his world is crucial, it seems to me, in providing a more contextualised, less objectifying understanding of depression while at the same time avoiding the kinds of linguistic determinism that have been much criticised in both social constructionism and post-structuralist

frameworks. This relational understanding of lived experience is something I return to in Chapter 4 and later in the thesis.

For me, both Burr and Butt very usefully illustrate some of the ways in which phenomenology is compatible with the social constructionist framework and, in fact, can enhance it. Perhaps what is needed is some form of what May (1992: 3) termed 'social existentialism':

> …which derives from Heidegger, Jaspers, and the late Sartre [and which] sees the self as a social construct, and a function of the interplay of history, social conditioning, and the chosen behaviour of the individual person.

This notion of 'social existentialism' for me illustrates just how useful social constructionism and phenomenology are to each other, indeed they are both able to enhance one another. By more fully acknowledging the complex social and historical context of personal lived experience we are able to gain a much more meaningful picture of the relational world, of what it means to be-in-the-world-with-others[4]. Thus, in this thesis the social and relational elements of existentialism and phenomenology will be central to an understanding of the experience of depression.

2.9 Summary

In this chapter I have described the development of some of the key theories and critiques in social constructionism along with the ways that some post-structuralist and phenomenological ideas are able to address some of the gaps and shortfalls in this alternative approach to Psychology. I have done so – in a spirit of reflexivity - in a way that also reflects my own personal journey through these concepts. Following the discussion above, in this thesis I adopt a broadly social constructionist

[4] The use of hyphens here – in the spirit of Heidegger's writing/thinking – aims to show the interrelatedness/holistic nature of these words/concepts which the standard use of language separates out.

conceptual framework but one that is also informed by post-structuralist ideas, especially the work of Foucault. At the same time, phenomenology is central to the methodology used here and I discuss this approach in more detail in Chapter 4, part 1. While the focus of this thesis is the lived experience of depression, I have aimed to show that it is important to also acknowledge, in some way, the aspects of its broader social, cultural and relational setting. Later on, in Chapter 4, I discuss why existential-phenomenology, in particular the work of Martin Heidegger, is well suited to this aim.

Chapter 3 Literature Review

3.1 Introduction

In this chapter I review some of the research and other literature relevant to this thesis. Following a discussion of the nature and identity of the profession of Counselling Psychology, this review focuses primarily on personal, autobiographical accounts of depression, the conceptualisation of depression in clinical/abnormal psychology and historical and cross-cultural writing and research, all of which in various ways aim to represent, characterise and investigate the lived experience of depression. Following a brief account of the social history of melancholia and depression, I explicate some of the clinical/abnormal psychological frameworks utilised to understand and diagnose depression. I then review key studies concerned with clients' experiences and lay, or 'everyday', understandings of depression, where the main focus is on a range of autobiographical literature. I then review some of the key cross-cultural research on the experience of depression and finally, I summarise the key themes and issues in this literature and relate these to the aims and objectives of this project.

3.2 What is Counselling Psychology?

In this section I address the topic of the nature and identity of Counselling Psychology as a profession in its own right and its place among the other applied areas of psychological practice. As the profession has grown and developed there have been ongoing debates concerning what exactly the profession is and how it differs from related practices such as clinical psychology and general counselling and psychotherapeutic practice. I argue here that the early tensions between humanism/phenomenology and natural science, between a focus on the core therapeutic relationship or 'alliance' and the psychiatric/medical models of

psychopathology, still abound even though these tensions and debates have developed and become more complex, (see Woolfe, 2016 for an up to date account). Furthermore, these tensions are also related to the history and development of social constructionism in psychology as outlined in the previous chapter and to my own personal and professional journey as both an academic and a practitioner psychologist.

Following the establishment of the British Psychological Society Counselling Psychology Section in 1982, its transformation into a Special Group in 1989, and the subsequent awarding of the status of a full BPS Division (on a par with Clinical Psychology) in 1994, the relatively new profession of Counselling Psychology has sought to differentiate a philosophy of its own in order to clarify and refine its professional identity and to separate it out from other specifically psychological practices. In an early (1990) article on the emerging profession entitled 'Counselling Psychology in Britain: An idea whose time has come' Ray Woolfe (1990: 531) noted the lack of not only dedicated training courses and established career paths but crucially a foundation in knowledge:

> Britain still lacks an established infrastructure of recognised training courses, avenues for occupational employment and advancement, or even a clearly defined knowledge base.

In this article Woolfe sought to explicitly address this perceived lack of a clear knowledge base and at this early point in the profession argued that counselling psychology needed to develop 'a scientific basis', a not uncommon feeling at that time (op cit: 533). At this time, Woolfe acknowledged that counselling psychology incorporates aspects of art as well as science and here the current and ongoing tensions between the two major poles of the identity of Counselling Psychology –

natural science/experimentation/objectivity and phenomenology/humanism/social science - are clearly evident at this early stage. On the one hand there is an emphasis and commitment to humanistic counselling practice with a focus on the value and efficacy of the therapeutic or helping relationship (and this includes a questioning stance towards science and psychopathology) and on the other a need for a 'scientific basis to counselling' concomitant with its status as psychology rather than more general counselling and/or psychotherapeutic practice. However, in spite of this call for a scientific basis, Woolfe takes a clearly anti-pathology stance in this paper (which he continues to take today) and compares counselling psychology to clinical psychology thus, coming down on the humanist side of the tension:

> …it does seem to me that there is a difference of emphasis here and that counselling psychology is focused more centrally towards thinking in terms of prevention and enhancing development rather than cure. This is characterised by an emphasis on wellness as opposed to pathology and one of its key aspects is the adoption of a more holistic view of the client. This means examining emotional and mental health in the context of an individual's location in the life cycle, as well as their lifestyle and relationships. (Woolfe, 1990: 532)

Also in 1990, Emmy van Deurzen (van Deurzen-Smith, 1990) argued – as she has continued to ever since – that the wisdom and insight found in philosophy provides a sound basis for counselling psychology practice and described her fears that counselling psychology might become subsumed by scientific/experimental psychological methods and frameworks:

> …how much of psychology has become caught up in the scientific model, involving outcome studies, with less attention given to the wisdom and hope that the author feels is explored within practice with clients …counselling psychology should be based upon the methods of critical comparison and philosophical insight rather than the rigid frameworks of experimental psychology. (van Deurzen-Smith, 1990: 8)

In the second edition of the much cited Handbook of Counselling Psychology, Strawbridge and Woolfe (2003: 5) usefully re-frame this tension as between 'being-in-relation' and 'technical expertise' and suggest that the root of the tension lies in the way we define science and its relationship to values. Once again there is a strong commitment here to broadly humanist concepts and values and these authors see this commitment as an important aspect of that which differentiates Counselling from Clinical psychology. With respect to the medical model, they go on to argue that the scientific language of psychological diagnosis places an increased distance between experts and those who experience particular mental states:

> …as the terms describing mental states become apparently ever more 'scientific', they are increasingly distanced from the language of those who experience these states and it becomes more difficult for the non-expert to challenge such 'expert diagnoses'. (Strawbridge and Woolfe, 2003: 17).

I very much concur with Strawbridge and Woolfe and in this chapter I place a great emphasis on the autobiographical 'first-person' literature concerning the experience of depression in addition to providing a review of the clinical/abnormal psychology accounts. Moreover, following from the social constructionist perspective adopted in this thesis, I also review some key relevant historical and cross-cultural research.

One crucial element in the debates concerning the identity of the profession is the image/metaphor of the 'scientist'-practitioner' which found its way from clinical psychology into counselling psychology and which has been defined as a model which 'aims to integrate science and practice to provide a uniquely qualified professional to work in a range of health, human service, organisational and educational settings' (O'Gorman, 2001: 164). More recently, this notion has, to

some extent, been displaced (though by no means entirely) by the already established model of the 'reflective practitioner', defined as a practitioner who:

> …reflects-in-action [and] tends to question the definition of his [or her] task, the theories-in-action that he brings to it, and the measures of performance by which he is controlled. And as he questions these things, he also questions elements of the organizational knowledge structure in which his functions are embedded. (Schon, 1983: 337).

This model of the 'reflective-practitioner' could be argued to have addressed something of the tension between 'being-in-relation' and 'technical expertise'. As Clegg and Gall (1998: 330) have suggested 'The idea of reflective practice cuts across the theory-practice axis, making personal knowledge and interaction as important as command of technical skills.' However, while the significance of natural/objective science in more contemporary definitions of counselling psychology practice may have been questioned (Woolfe, 2016; Strawbridge, 2016) and, for some, side-lined, I argue here that, by definition, and given the nature of the discipline of psychology, it can never be straightforwardly overstepped or entirely removed.

Thus, these earlier and more recent reflections on the nature of the discipline point to continuing ambiguities and possible conflicts. However, even though for these influential authors scientific and psychopathological perspectives must be treated with caution, for me, it is clear that the emergence and continued existence of a profession which brings together counselling practice with psychological theory and research means that there must always be some degree of tension and even contradiction between these different elements. Indeed, it could be argued that these contradictions and tensions are part and parcel of psychology itself and have been since very early in its development. Importantly, these tensions can still be seen in the current agreed definition of Counselling Psychology which can be found in the BPS professional practice guidelines:

> Counselling psychology has developed as a branch of professional psychological practice strongly influenced by human science research as well as the principal psychotherapeutic traditions. *Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology*. It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship. (DoCP, 2005: 1, my emphasis).

Although this thesis is specifically focused on the experience of depression and the literature reviewed in this chapter reflects that, I also wish to emphasise the importance of reflection on both the identity of the profession of counselling psychology and my own personal professional identity as a counselling psychology practitioner. In some ways my own journey as an academic and as a practitioner has embodied many of the tensions described above. While I firmly situate myself within the social constructionist perspective, I also believe in the value and utility of a scientific approach in certain contexts, although I would describe most aspects of psychology as a human or social science rather than a natural science. I return to these issues throughout the thesis and in more detail in Chapter 7.

3.3 A brief social history of depression and melancholia

One key means of understanding the complexity of the experience of depression is through exploring its historical development, especially in relation to the early accounts of the experience of 'melancholia'. Indeed, there is a complex and illuminating history of melancholia and depression which can enable a more extensive understanding of the meaning and experience of depression in our contemporary present. Here, for the sake of illustration and brevity, I highlight some of the major shifts in its understanding in the West.

This social historical analysis begins with three key observations. Firstly, the reality of melancholia in the past was different to the reality of current day 'depression'. Secondly, at any particular point in history, different realities or understandings may exist together; for example, the reality of 'melancholia' for the inmate of Bedlam was very different to that of the 'world weary' poet and traveller. Thirdly, constructed realties provide the individual with a means by which to organise their experience, in Harré's (1986: 226) words, '…in the course of the long history of melancholy, the accounts of it take on a prescriptive force over and above their original role in the medical symptomology'.

In Ancient Greece, melancholia was considered to be a temperament and an illness, both of which related to a physical condition caused by the predominance or excess of black bile which was conceptualised as one of four humours; blood, choler (or yellow bile), phlegm and melancholy (or black bile). Porter (2002) describes these humours as 'vitality-sustaining juices' (p37) and describes the way in which these humours became linked to notions of health and ill-health and also to the temperaments or what we would now call psychological dispositions:

> ...humoral thinking had ready explanations for the plunge from health into illness, both physical and psychological (though in a holistic system, these were never polarised). All was well when the vital fluids cooperated in their proper balance. Illness resulted when one of them gathered (became 'plethoric') or dwindled… Specifically in terms of mental disorder, excesses both of blood and of yellow bile could lead to mania, whereas a surplus of black bile – being too cold and dry – resulted in lowness, melancholy, or depression. (Porter, 2002: 41)

As Bennett (1978:18) states 'a black and bitter mood was associated with a black and bitter substance'. The four humours referred to by Aristotle and Hippocrates remained as the basis of medieval characterology where an excess or dwindling of one of the four humours was still seen as causing illness, while different

seasons and times of day were seen as amplifying the effects of the associated humour. Autumn and night were the most likely times for melancholia to occur. Furthermore, throughout the Middle Ages and the Renaissance melancholia remained fundamental to constructions of personality types and mental illness. In fact, by the late Middle Ages, the favourable and unfavourable aspects of melancholia were well established; as indicative of either a particular temperament, intellectual aspiration or as diabolical possession.

During the Elizabethan period in Britain melancholia came to mean general madness (Skultans, 1979) and was seen in a pathological context where a great number of different aspects of melancholy were described though in a moral context; 'melancholics' were still subject to continued witch hunting. A mad/gifted dualism emerged during this time and continued into the Eighteenth century and, as the importance of melancholia as a way of understanding personality and mental illness spread, it came to have new names; the spleen, the vapours, hypochondriasis, hysteric fits, the 'hyp', and even the 'English Malady'. The English Malady was restricted to literate or more accurately literary circles, but alongside the fashionable nervous ailments Bedlam and other houses of confinement existed where inmates were treated as less than human. It was not until the end of the eighteenth century and the beginning of the nineteenth century that the concept of melancholia began to move closer to our concept of depression, with its emphasis on 'psychological' factors such as fear, guilt, hopelessness and inertia, primarily through the rise of psychiatry.

From 1750 onwards, a distinctly psychological explanation of madness (and melancholia) emerged. Following the appearance of the philosopher John Locke's highly influential ideas, Cartesianism (where rational, sane, reasoning consciousness

was contrasted with madness as a physical, bodily illness) was replaced with the belief that madness (and depression) must be a product of mis-associations of thoughts and ideas, where madness was '…essentially delusional, a fault in cognition rather than in will or passion' (Porter, 2002: 60), thus melancholia becomes transformed into a 'mental' disorder. This new way of understanding madness (and depression) gradually became medicalised throughout the eighteenth and nineteenth centuries while the term 'depression' (from the Latin *deprimere* 'to press down') progressively came into use during the eighteenth century and beyond (Jackson, 1986: 145-146).

This gradual medicalisation of depression culminated in the emergence from the 1940's onwards - following the development of penicillin and anti-biotics - of modern psychopharmacology, which led to the development of drug treatments for depression including so-called 'designer' anti-depressants, currently the SSRI's (Selective Serotonin Reuptake Inhibitors) and SNRI's (Serotonin-Norepinephrine Reuptake Inhibitors). In the last few years, there has been an explosion of psychopharmacological treatment for depression both in the UK and globally and a recent study (Spence, Roberts, Ariti and Bardsley, 2014) found that there was a 165% rise in the prescribing of anti-depressant drugs in the UK between 1998 and 2012.

Alongside the rise of psychopharmacology there has been the development of comprehensive and international diagnostic systems, most notably the ICD (International Statistical Classification of Diseases and Related Health Problems) and the DSM (Diagnostic and Statistical Manual of Mental Disorders). Much has been said about the proliferation of categories and types of mental disorder as these

systems have steadily developed and of relevance here is Porter's (2002: 214) observation regarding what he calls the 'explosion of scale':

> Most telling of all has been the sheer explosion in the enterprise's [DSM] scale: the first edition [1952] was some hundred pages; DSM-II run to 134 pages, DSM-III to almost 500; the latest revision, DSM-IV-TR (2000) is a staggering 943 pages. More people seem to be diagnosed as suffering from psychiatric disorders than ever; is that progress?' (Porter, 2002: 214)

The newest edition DSM-5 (2013) runs to 1000 pages.

From this very brief sketch of some key events in the social history of melancholia, it becomes clear than an experience such as depression should not be abstracted from its social and historical context. Ancient Greek melancholy was a somatic disorder which varied according to the weather; the melancholy of the 'malcontent' from the end of the sixteenth century, a fashionable pose; the melancholy of the Elizabethan lower classes, madness which required subjugation. The rise of psychiatry and then psychopharmacology evidence new constructions of madness and depression which continue to develop through the expansion of the comprehensive diagnostic systems. Finally, the variety of ways in which melancholy and depression have been constructed and experienced, both across time and within the same cultures, suggests that a narrow, clinical/abnormal psychology based conception of contemporary depression may be overly restrictive given that this form of understanding individualises and psychologises the experience, removing it from its broader social, cultural, relational and moral context. Such a conception also risks objectifying and even dehumanising those who experience depression.

3.4 Clinical and 'Abnormal' psychology

Mainstream psychological theorising concerning depression comes primarily within the remit of the sub-discipline of 'Abnormal Psychology', where Clinical Psychology forms its related practice-focused domain. Here I will briefly outline the key conceptualisation of depression within this sub-discipline and critically reflect on some of its strengths and shortcomings.

Major depression is conceptualised under an umbrella category of 'mood disorders' which includes for example 'bipolar disorders', 'disruptive mood dysregulation disorder', 'persistent depressive disorder' (previously dysthymia), 'premenstrual dysphoric disorder' and other types of 'abnormal' mood. The different labels and diagnoses have changed and developed over many years through the different iterations of the DSM, up until its current form the DSM-5, published in 2013 (please see chapter 1 for a summary of the DSM-5 diagnostic criteria for major depression). Another commonly used diagnostic system with an alternative, though similar, set of criteria is that found in the ICD-10 or the International Classification of Diseases version 10, originally published in 1992 and regularly revised, although a new version is due for publication in 2017. The ICD-10 (2016) diagnostic criteria for major depression are as follows, where depression is measured/diagnosed as either mild, moderate or severe according to the number of criteria/symptoms that have been identified:

> In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may

> be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe. (ICD-10, 2016 version).

Earlier versions of the ICD-10 (1992) provided a list of symptoms as follows, which were also similar to the DSM criteria:

> The individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness after only slight effort is common. For depressive episodes of all three grades of severity, a duration of at least 2 weeks is usually required for diagnosis, but shorter periods may be reasonable if symptoms are unusually severe and of rapid onset. Other common symptoms are:
>
> (a) reduced concentration and attention;
>
> (b) reduced self-esteem and self-confidence;
>
> (c) ideas of guilt and unworthiness (even in a mild type of episode);
>
> (d) bleak and pessimistic views of the future;
>
> (e) ideas or acts of self-harm or suicide;
>
> (f) disturbed sleep
>
> (g) diminished appetite

The ICD-10 definition along with the DSM-5 definition described earlier in Chapter 1, give a good sense of the clinical/abnormal psychological understanding of major depression as a *syndrome*, as a cluster of related, associated and consistent symptoms which are conceptualised as the expression of some underlying ‘disorder’. The medical model is central to these conceptualisations where psychological disturbance is seen in terms of disease, in the same way as physical, bodily conditions would be.

One key element of abnormal/clinical psychological definitions of depression (and other mental disorders) is the central defining feature of deviance or

abnormality. The following description clearly illustrates this centrality of the notion of deviance:

> Depression is defined as a persistent and deviant lowering of mood and/or a loss of interest in usual activities, accompanied by a variety of distinctive signs and symptoms. The depressed mood differs from normal sadness or unhappiness by its inappropriateness to the situation, intensity, duration and the effect it has on the life of the person who is experiencing it so that it interferes with normal living. (Ramsden, 2013: 269)

Usually this notion of abnormality refers to deviance from some statistical and/or behavioural norm or some other version of 'normality', and of course much has been written about the complexity and pitfalls of defining what we take to be 'normal' and 'abnormal' (for example, Foucault, 2006; Rose, 1985, 1999; Szasz, 2007). Here I simply wish to make the observation that despite claims to a scientific and objective (disinterested) stance, any theory of the human condition must, by definition, come from a particular perspective or standpoint, it must draw upon some notion of what it means to be human and, in turn, what it means to be a 'normal' human; what it means to behave 'appropriately'. Moreover, the ways in which we define normality and abnormality will always be bound up with the social, cultural, political, economic and especially historical process through which they are shaped and constructed, and crucial among these is what is termed the 'moral order' – defined as a body of unwritten rules and prescriptions and proscriptions which maintain what is good, right, virtuous in any culture or society – and this is fundamental in that it affords a kind of compass for where to direct our attention in our understandings of persons and the wider world.

One useful example of the ways moral order is bound up with psychological theories and categories can be taken from the following definition of a 'normal' person, posted by psychiatrist Frederic Neuman in *Psychology Today* during 2013:

> What sort of person is a normal person? He is someone, first of all, who feels happy a considerable part of the time. Not all the time, of course. He is angry when he is frustrated, disappointed when he fails. He grieves when he has lost someone. Sometimes he is frightened. But he is not characteristically in any single mood, for there is an aptness to his feelings, a fit between them and the circumstances of his life. Since the circumstances of every person's life are varied, so are his feelings. Still, in general he thinks of himself as being happy. He can relate to other people, being assertive when appropriate and conciliatory at other times. He may not feel comfortable with everyone, but he does feel secure within his family and among his friends. And there are groups - religious, perhaps, or social - with whose members he feels an identity. And he can love, which means he can be trusting and affectionate. And he can make love without feeling oppressed or uncomfortable. Such a person often finds himself committed to other people, or even to an idea, to a degree where he loses himself in a larger purpose. Consequently when he has children, he becomes part of them and continues on in their lives, so that personal death becomes less real and less frightening. (Neuman, 2013)

This version of normality illustrates on the one hand that descriptions such as this can resonate with our common sense, we might not agree with everything here but we know what the author is trying to convey. On the other hand, it also illustrates the minefield that one enters once we try to define what is 'normal' for a single culture, let alone the entire human race. It is interesting that the 'normal' person depicted here is a male who will inevitably have children, and whose (always appropriate) behaviour and emotions conform to a version of what might be described as the emotionally adjusted citizen. 'His' feelings always fit with, and are always appropriate to his circumstances, there is a sense of security and trust and this 'normal' person often finds himself committed to other people and/or to a larger purpose. Here we can begin to see the implicit moral order in this version of the 'normal' person, indeed this description might serve as a useful representation of how persons *should* conduct themselves, the kinds of conduct they should aspire to. As Burman (2007) has so cogently argued, in psychology what begins as *description* can often meld seamlessly into *prescription*. Moreover, 'making love without feeling

oppressed or uncomfortable' assumes a social and cultural situation where this would be possible, difficult for example if you are lesbian, gay, bisexual or trans in a country which hands out prison or even death penalties to members of sexual minorities, reminding us again of the kinds of assumptions being made here.

As I have said, my purpose here is not to dismiss the value and utility of the vast amount of knowledge and experience tied up in the current diagnostic systems but to properly acknowledge their limitations and, more importantly, their historical, cultural, political, and economic conditions of possibility. Indeed, some have argued that key members of the DSM-5 panel had financial links with drug companies (Cosgrove and Krimsky, 2012) while others point to the continued reduction of the thresholds of 'abnormality' in the latest version of DSM:

> Successive revisions of psychiatric diagnostic manuals have generally reduced their thresholds for making this distinction [between major depression and just feeling miserable], such that someone who would have been considered miserable but healthy in the 1950's might be diagnosed with a major depressive disorder from 2013 onwards. (Field and Cartwright-Hatton, 2015: 3)

Further on in their text, Field and Cartwright-Hatton (op cit) posit a fictional world where psychological disorders are not categorised at all, for these psychologists such a world would mean that mental health disorders could not be treated without a category to make sense of and to label the 'disorder':

> Imagine a parallel universe in which psychological disorders are not categorised, everyone is treated as an individual and similarities between people are ignored. Bob goes to see his doctor complaining of hearing voices… The doctor has no idea what to do, so he just tries different treatments at random. He refers Bob for some counselling but this doesn't help. Neither do antidepressant drugs. If only somebody had recorded the details of previous patients who had similar symptoms and signs to Bob! (Field and Cartwright-Hatton, 2015: 7)

This scenario, rather than convincing me that categorisation and generalisation is essential, instead points to the difficulty and complexity of acknowledging both that some psychological distress does seem to fall into distinct patterns with similarities between different people who suffer and - contrary to the above quote – the importance of treating everyone as an individual, as a unique human being who occupies their own complex, unique life-world.

3.5 'Lay' and autobiographical accounts

There is a significant body of writing concerning 'lay' or everyday experiences of depression which includes personal, autobiographical narratives and there has been some proliferation and an intensified interest in these personal accounts over the last few years. Vicky Rippere (1977), who was at the forefront of the early work in this area, found that non-depressed lay persons have extensive and accurate knowledge about depression and this led her to argue later that the distinction between depressed and non-depressed clients is difficult to sustain given that most clients who attend therapy are depressed to some degree, (Rippere, 1994; Rippere and Williams, 1994). This blurring of the boundaries between depressed and non-depressed clients, I suggest, also applies to the lay population more generally and is further reflected in the powerful ways in which depression, melancholia and sad 'blue' mood are so profoundly embedded in Western culture, including art, fiction, literature and music. Everyday accounts of depression from those who may or may not have been formally diagnosed enable a more complete picture of the experience of depression to emerge - in comparison with that given through the diagnostic and clinical accounts - and in a way that fully allows for wide variation in accounts and experiences as well as for the similarities between them.

Many writers in this area convey the real difficulty in finding the right words to describe their depression and their struggle to communicate the fullness and depth of the lived experience. For example, in Rippere and Williams' (1994) ground breaking text 'Wounded Healers' one contributor (Clinical Psychologist, anonymous), finds the use of metaphor helpful and this appears to be the case for so many who try to describe their depressed feelings. Here she/he describes their experience of 'failing powers of thinking' (Rippere and Williams, 1994: 100), and of finding any kind of activity extremely difficult:

> It is exceedingly difficult to give a description that does full justice to the scope of a global condition such as depression. One of the best metaphors for depression, as I experienced it, is 'wading through mud'. The expression captures the feeling of powerful resistance opposing and impeding any kind of action: thought, word or deed. (Clinical psychologist in Rippere and Williams, 1994:101).

Not being able to find the words to convey one's depression is also tied, for some, with a compounding of the negative feelings. Here a former mental health worker describes the way that not having a vocabulary made the depression worse:

> What was so bad about it [was that] I had no words for it. I didn't understand [what is was]. It was definitely like a total abyss, you know, where everything that I'd ever counted on was gone somehow. Yeah it was terrifying to me… you know and the pain is really kind of raw just because you have no vocabulary for it, and you'd never experienced it before [female health worker, aged 27]. (Karp, 1996: 40)

The onset of depression is also widely depicted in these personal accounts. In his recent best-selling text Reasons to Stay Alive (2016), Matt Haig opens with a description of the moment when his first bout of serious depression began:

> It started with a thought. Something was going wrong. That was the start. Before I realised what it was. And then, a second or so later, there was a strange sensation inside my head. Some biological activity in the rear of my scull, not far above my neck. The cerebellum. A pulsing or intense flickering, as though a butterfly was trapped inside, combined with a

> tingling sensation. I did not yet know of the strange physical effects depression and anxiety would create. I just thought I was about to die. And then my heart started to go. I sank, fast, falling into a new claustrophobic and suffocating reality. And it would be over a year before I would feel anything like even half-normal again. (Haig, 2016: 9)

The notion of falling into another world or experience is something that many other writers in this area describe. Kelly (2014) depicts in detail her sensation of falling, which for her recalled a memory of an actual emergency landing. Kelly's depiction also provides a striking example of the extent to which depression is experienced as an embodied as well as a psychological or 'mental' phenomenon:

> I had this terrifying sensation that I was continuously falling, hurtling downwards as if on a crashing plane. I had once been on a plane that landed under emergency conditions in Dubai. The feeling was similar: I was braced, rigid with fear, waiting for the crash. This time the landing didn't happen… I had a permanent headache, as though dozens of vicious, heat-maddened wasps were massed behind my eye sockets, stinging my soft, unprotected brain. My rancid stomach fiercely knotted and re-knotted itself, spinning in a sharp pointed pirouette. I no longer even seemed to be able to throw up. I kept repeating that I was going to crash. (Kelly: 2014: 9-11)

For Haig (op cit) above there was, in retrospect at least, a clear beginning to his depression, whereas others have depicted a more nebulous onset. Here Ruby Wax portrays her gradual journey into what she describes as 'a tsunami of despair' (Wax, 2003:182):

> The minutiae of life started eating me alive; I had lost the big picture. I knew this because my life became consumed by making lists and when one thing got crossed off the list, more things grew in its place. I was holding on to sanity by giving myself 'things to do': buy toilet paper, change light bulb, get car washed, clip children's toenails, brush teeth. The inside of my head became like Hong Kong: strobing neon on big billboards flashing day and night, day and night. (Wax, 2003: 181)

Depression can begin in many different ways and the autobiographical literature reminds us of the necessity of acknowledging the wide variety of experiences of the onset of depression. Lewis (2011), for example, depicts an

initiating event in which she was unable to stop crying, followed by a long period of sleep, and also illustrates how, for some people who suffer from depression, recovery can be a very long road:

> I gave in to my most recent bout of depression when I started driving to work one day and found that I couldn't stop crying. I thought this was odd and drove home… I went to bed and slept almost continuously for two weeks. It was five weeks before I could read again and I was off work for eleven months in all. It was two years before I began to feel like myself again. (Lewis, 2011: xiii)

There are also descriptions of the intensity, depth and power of the feelings experienced during major depression. The following quote provides a compelling illustration of the experience of breaking down, widely reported in these accounts, where there is an experience of a complete disintegration of oneself:

> Sometimes the final realisation that you can no longer function or continue with life is called a breakdown. It's a phrase rarely used by mental health professionals; it's considered too patronising or demeaning. It's sufferers themselves who use the expression most often, perhaps because it perfectly describes that state of total collapse. You no longer have control over anything: thoughts, emotions, sleep, appetite. You are, quite literally, broken down. To me it felt like the total disintegration of everything I had ever known about myself. (Brampton, 2009: 42)

In another description, the author William Styron stresses that major depression is very different from what he termed the 'manageable doldrums' (Styron, 1990: 7). The ICD-10 lists 'depression worse in the morning' as one possible somatic symptom, however Styron experienced something different:

> While I was able to rise and function almost normally during the earlier part of the day, I began to sense the onset of the symptoms at mid-afternoon or a little later – gloom crowding in on me, a sense of dread and alienation and, above all, stifling anxiety. (Styron, 1990: 12)

Styron goes on to describe the gradual diminishing of his ability to concentrate and then his inability to do any work (writing) at all. Fear and anxiety were also at the heart of Styron's experience of depression:

> …I felt an immense aching solitude. I could no longer concentrate during those afternoon hours, which for years had been my working time, and any act of writing itself, becoming more and more difficult and exhausting, stalled, then finally ceased… There were also dreadful, pouncing seizures of anxiety. One bright day on a walk through the woods with my dog I heard a flock of Canada geese honking high above trees ablaze with foliage; ordinarily a sight and sound like that would have exhilarated me, the flight of birds caused me to stop, riveted with fear, and I stood stranded there, helpless, shivering, aware for the first time that I had been stricken by no mere pangs of [alcohol] withdrawal but by a serious illness whose name and actuality I was able to finally acknowledge. (Styron, 1990: 46)

Styron's depiction illustrates well the role of extreme fear and anxiety in some experiences and he goes on to say that he felt at this time as if he was going mad, 'I couldn't rid my mind of the line of Baudelaire's… "I have felt the wind of the wings of madness" (Styron, 1990: 46).

In addition to an experience of loss of self, of dread, anxiety and alienation, there are descriptions of hopelessness and a sense of being overwhelmed by the depression:

> I would say it kind of feels like somebody is holding a match that's lit and just the flame is really hot and you're trying to stand it, and it's just consuming you more and more and then it just gets down to the end and there's no more, and the consuming part is just complete hopelessness. You start off as a whole person and then little by little things that you care about start floating away and they're not important anymore and they get harder to hold on to… the easiest thing to do is to just to lie down and let it consume you. (female Nanny, Karp, 1996: 21)

There are also accounts of suicidal thoughts and suicide attempts throughout this literature. What comes through from these accounts is the deep and dreadful anguish and despair that can occur when there really seems no way out of the

depression, or the ‘prison of depression’ as Dorothy Rowe described it, other than taking one’s own life. Moreover, these thoughts of and/or planning of suicide can endure even after the depressive episode. Here a Senior Nursing Tutor describes her feelings of isolation, helplessness and her continued belief that suicide would be a way out of similar circumstances should they happen again:

> What went with this [‘crying and complaining’ over health difficulties] was my firm conviction, not only that I would never get any better, but also that life was not worth living. It seemed quite obvious to me that I ought to have committed suicide, but I was too incompetent, indolent, and helpless to do it. My preoccupation with ending life was very pressing for a long time and has certainly not left me entirely. At the moment life is good but given the cumulative difficulties, as I perceived them at the time, it would have been better to be dead. Should a similar set of circumstances ever happen again, I hope to be better prepared than I was the last time to take my life. (Senior Nursing Tutor, Rippere and Williams, 1994: 168)

Sadly, one of the contributors, a General Practitioner succeeded in taking her own life shortly after Rippere and Williams’ (1994) book was published. Here she ends her account with her wish that if her situation worsens circumstances will not prevent her from carrying out her suicide plan:

> Even in my happiest periods, when I look forward to a long and fruitful life, and the very thought of suicide is abhorrent, I am still not at all grateful for being rescued from attempts in the past… I am fortunate now in having the means and opportunity to kill myself without fear of failure should the need once more arise. My strongest wish is that if the present depression deepens, then it will progress too rapidly to allow anyone to detain me compulsorily before I have time to reach the point at which suicide becomes mandatory. (General Practitioner, Rippere and Williams, 1994: 175)

Many of these autobiographical accounts of depression are also stories of recovery, of lessons learnt, of the slow path back to oneself. For example, for Lewis (2011: 207) depression should be seen as a call to identify what is wrong with, and to make changes to, one’s life:

> This is where you need to turn detective. Your depression is the most important case of your life: you must probe, agitate and investigate until the whole sordid story is out in the open. If you weren't ashamed of it, you wouldn't have hidden it in the first place. This may take a long time, and psychotherapy or therapy may be necessary… Your mission is to find out what needs to change in your life and to change it. (Lewis, 2011: 207)

Haig (op cit) describes an event at the start of his recovery when he attended a party, always a difficult experience for him he says, where he had a kind of relapse and hastily left the event. However, this time his panic attack stopped:

> …my panic attack had gone. In the old days, my panic attacks didn't just go. They simply morphed into more panic attacks, breaking me down, like an army, until depression could come in and colonise my head. But no. I was feeling quite normal again. A normal person who was allergic to parties… That itself was progress. A year later I would be better enough to not only go to the party, but to travel there on my own. Sometimes on the rocky, windy path of recovery, what feels like a failure can be a step forward. (Haig, 2016: 200-201)

There are also concerns over stigma and prejudice. A very common theme in these accounts is the experience of feelings of shame along with the stigmatisation of mental disturbance and illness and the ways this makes telling others and getting help so much harder:

> I am mentally ill. It doesn't mean I will stab you or stalk you or demand a low-calorie recipe for cheesecake when I am sitting next to you on the Tube. It doesn't mean I will dribble or smell or abduct your infants or infect your pets. It doesn't mean I want to rule the world or take risks with your money or corner you at a party and talk about depression… I don't think it's a condition that should invite prejudice. People with lung cancer and heart disease are not ostracised or humiliated or debarred from jobs or opportunities, even though in some cases their lifestyle will certainly have contributed to their affliction… No wonder most of us keep our thing to ourselves. (Rice-Oxley, 2012: 280)

With regard to other research into the experience of depression, there is an emphasis on finding commonalities within samples of participants, identifying types of narratives used in conveying the experience of depression and a focus on issues

concerning gender. For example, Kangas (2001) conducted in-depth interviews with depressed people with a particular focus on the participant's narrative structures. Kangas distinguished three narrative types. Firstly, a storyline based around early-life development, in particular shortcomings in childhood. A second storyline focused on overwhelming demands and work-related burn out. A third storyline centred on causative factors which included severe life events in adulthood. Kangas also found that in each key narrative there was reflection upon other narratives of depression and a presentation of the experience as a 'legitimate form of suffering' (Kangas, 2001: 90) and as a form of illness rather than a type of madness.

Other studies have explored the relationship between gender, gender-identity and depression in everyday accounts and narratives. For example, Emslie, Ridge and Ziebland (2006) used narrative analysis to explore the relation between masculinity and help seeking in depressed male patients. They analysed sixteen in-depth interviews with depressed men across the UK. It was found that reconstructing a valued sense of masculine-identity was a key element of the participants' recovery. Various strategies were identified in this regard including the incorporation of hegemonic masculinity into the illness narratives. In addition to these positive strategies there was evidence that pressures to conform to hegemonic masculinity could contribute to suicidal behaviour.

Walters (1993) in a study of 356 Canadian women, found that stress, anxiety and depression were the most frequently reported health problems. Walters found that when the participants talked about the sources of their mental distress these were often located within a broader context of social influence and often in relation to gender identity:

> They emphasized the social aetiology of mental health, noting the importance of gender roles and images of women. They described the heavy workload of women, issues of identity and their social legacies. (Walters, op cit: 393).

Walters concluded that the women in her sample tended to normalise their distress and that this may reflect the wider societal and cultural lack of validation and reinforcement of women's experience of health problems.

The complex and subtle ways in which gender inequalities are reproduced in discourses of madness and mental illness have long been recognised (for example, Chesler, 1972/2006; Ussher, 1991; 2005). Part of this reproduction of inequality is related to a wide-spread lack of recognition of the specificity of women's experiences and a concomitant lack of cultural and medical validation. LaFrance (2009) conducted a discourse analytic study of understandings of depression using a women-only sample. She found that women's accounts were deeply influenced by medical discourse. By objectifying their depression as an independent identity (or diagnosis), women were able to seek comfort and validation for their feelings. Negative experiences of stigmatisation were also discussed by these women, and despite placing their distress within a medical framework, their experience still felt illegitimate in comparison to other more validated diseases.

3.6 Cross-cultural analysis

Although many cultures have expressions or concepts that appear similar to our Western term 'depression', it is crucial to understand that such 'equivalent' terms are often embedded in an entirely different social and cultural context. Furthermore, as I have previously argued, an important part of this context is the culture's prevailing moral order, often downplayed or even ignored in the mainstream clinical/abnormal psychological literature. In this section I review some cross-cultural research in order

to provide an example of the relevance of the cultural context to understanding personal experiences of depression.

There is a significant body of work in critical/alternative psychology which explores the social construction of emotions. This work makes a case against physiologically and otherwise reductionist accounts of emotions in favour of accounts which are sensitive to the (local) social, cultural and historical construction of emotional experience. If we take fear as one emotion that may form part of the experience of depression (and many other psychological disturbances), our western understanding of this term does not necessarily relate to concepts of fear in other cultures. Catherine Lutz (1986) in a well-known study of emotion words on the Micronesian atoll of Ifaluk showed that the word 'metagu' is used in contexts that are similar to those in which we use the word fear, that is, in the presence of a threatening or dangerous object. However, in other ways the concept of 'metagu' operates in quite a different sense. In the words of Harré (1986: 10):

> Among the Ifaluk, those who are submissive and passive in metagu [during provoking situations] are commended, while those who display an aggressive stance are condemned. The moral qualities with which the concepts are associated are such that it would surely be a gross mistranslation to treat 'metagu' as equivalent to 'fear'.

This example illustrates the role of the moral order in emotional experience, a role which is often more visible in cultures other than one's own.

Another example of the role of culture here is provided by Tanaka-Matsumi and Marsella (1976) who looked at the subjective experience of depression among Japanese nationals, Japanese Americans, and Caucasian Americans through the use of word associations to the terms 'depression' and 'yuutsu' (which through extensive back translation was considered to be closest to our term depression).

Word association patterns were very different for the Japanese National and the American sub-samples. The Japanese samples tended to use 'external' reference words such as 'rain', 'cloudy' and 'dark' whilst the two American samples tended to use internal reference words such as 'sadness', despair' and 'loneliness'. It appears then that where equivalent words do exist for depression they may be embedded in a different context which alters their meaning in complex ways.

More recent work has continued to show the culturally specific nature of depression. For example, Pritzker (2007) interviewed Chinese participants diagnosed with depression to explore the ways in which Chinese metaphorical language is employed to make sense of the experience. Pritzker argued that following a Cartesian mode of thinking, Western cultures have a tendency to split the mind and the body which are typically referred to using symbols of the brain and the heart respectively. In contrast, Chinese medico-philosophy enables the heart to be used as a metaphor for both thinking and feeling and this was largely confirmed in Pritzker's study.

Ryder, Yang, Zhu, Yao, Yi, Heine and Bagby (2008) sought to further explore the consistent findings that Chinese people are much more likely to report somatic symptoms of depression. In a Study of 175 Chinese and 107 Euro-Canadian outpatients, data was collected using a symptom questionnaire, structured clinical interviews and spontaneous problem reports. Chinese outpatients reported more somatic symptoms whereas Euro-Canadians reported more psychological symptoms. Ryder et al (op cit: 300) concluded that 'the relation between culture and somatic symptom presentation was mediated by a tendency towards externally oriented thinking'. Moreover, the psychological symptom effects were found to be larger than the somatic symptom effects. Given this and the findings from other

studies, which suggest the worldwide occurrence of somatic symptom reporting, the authors conclude that western psychologisation may be more culturally specific than the tendency towards somatic symptom reporting among Chinese people.

Mallinson and Popay (2007) undertook a qualitative exploration of Pakistani and White participants living in the UK who self-identified as depressed. There was a tendency for both groups, across age, gender and ethnic boundaries, to employ everyday and colloquial language to express their experience. Terms and tropes such as ‘low’, ‘down in the dumps’, ‘stressed’ and ‘under pressure’, enabled participants to make potentially alien feelings more familiar. This process was echoed with the use of metaphors, analogies and similes, for example ‘it just crashes over me’ and ‘washes over me’ were water related analogies used by participants in an attempt to express the overwhelming nature of depression. Whilst these themes were found in both groups, White participants had a greater tendency to refer to suicide, whilst the Pakistani group did not. Moreover, the White participants relied upon biomedical accounts of depression more than their Pakistani counterparts. Similar findings emerged in a study examining explanatory models of depression in Indian women of low income, with participants rarely drawing upon a medical discourse but emphasising somatic problems such as body aches, sleep and gynaecological difficulties (Pereira, Andrew, Pednekar, Pai, Pelto and Patel, 2006).

Finally, Kokanovic, Dowrick, Butler, Herrman and Gunn (2008) explored concepts of distress among different communities resident in Australia. They collected data from 62 Anglo-Australian residents concerning their experience of depression and 30 East African refuges. Participants were either interviewed or took part in focus groups. The following findings were reported:

> Anglo-Australian accounts frequently portray depression as an individual experience framed within narratives of personal misfortune, and which is socially isolating. In the accounts of distress from the Somali and Ethiopian refugees living in Australia, family and broader socio-political events and circumstances featured more frequently, and 'depression' was often framed as an affliction that was collectively derived and experienced. (Kokanovic et al., 2008: 454)

3.7 Summary

In this chapter the experience of depression has been considered in different ways and from different perspectives. Looking at the social history of melancholia and depression, it becomes evident that what we currently term 'depression' has markedly changed across time having been shaped by many different beliefs, ideas, practices and events. Likewise, cross-cultural research clearly evidences the cultural variation in the ways in which the experience of depression is described and made sense of, along with some of the problems encountered in trying to make translations of psychological and other terms across languages and cultures.

As would be expected, the abnormal and clinical psychology/psychiatric conceptualisation of depression, based upon a medical, nosological approach, presents a somewhat narrow, reduced account of major depression rooted in symptomology and the notion of depression as a syndrome. In contrast, the personal, autobiographical accounts of depression show a wide range of different experiences and the use of everyday language, as opposed to a clinical/biomedical vocabulary, enables the richness and complexity of the different experiences to emerge. However, it is also striking that the different autobiographical accounts share many key elements and themes, and some of these themes also correspond with the diagnostic criteria set out in the DSM and ICD; albeit where the personal accounts evidence many different and more varied events, patterns and interpretations. Thus, on the one hand the personal accounts support, to some

extent, the overall diagnostic criteria but at the same time these accounts highlight the reduced, restricted and partial nature of the nosological, diagnostic descriptions.

One important aim of this project is to allow participants to convey their experience of depression in a way that includes the key DSM diagnostic criteria but where participants are not limited to them. I will give participants a wide range of relevant statements with which to describe their depression (through an online sorting task) and these will include nine statements taken from the key DSM diagnostic criteria for major depression, which generally encompasses most types and severity of depression other than those with mania or psychotic symptoms. This way it should be possible to discern the role and meaning of the DSM criteria in participants' own accounts of their lived experience of depression.

As I previously stated (Chapter 1), my key objective is to document and explore the variety of experiences of depression among participants who have been diagnosed and/or self-report as having had an experience or experiences of depression, either currently or in the past. I ask the questions 'How do participants experience (clinical and non-clinical/self-identified/diagnosed[5]) depression? How do participants' experiences resemble or differ from established psychiatric and clinical psychology accounts of depression and how might the findings be relevant to existential counselling psychology practice?

[5] Self-disclosed diagnosis

Chapter 4 (Part 1): Methodology

4.1 Introduction

In this chapter I describe the methodology and the methods used in this project. As described in Chapter 2, this study utilises a qualitative design within a social constructionist conceptual framework. From a social constructionist perspective, I am primarily interested in the subjective meanings which participants ascribe to the experiences and events under examination, where language is conceptualised as, in part, playing a role in constructing the subjects and objects referred to in participants' accounts. Moreover, given the constructionist position of this thesis, I take a somewhat relativist stance to the data and do not assume these accounts represent more or less fixed or 'accurate' versions of the experience of depression but rather conceptualise them as versions (which are of course personal and experiential) that are in some sense situated; in part bound to their social, cultural, relational and temporal context and location. In terms of methodology I utilise an existential-phenomenological approach to method which at the same time should be seen as interlinking conceptually with social constructionism, in particular through a shared focus on both the nature and the conditions of possibility of lived experience.

This chapter is divided into two sections. In part one I focus on methodology with an account of the particular form of phenomenology used in this thesis, along with some historical and conceptual contextualisation of two key existential-phenomenological philosophies. In part two I provide an account of method for the preliminary phase of the study where data was collected using two focus groups constituted with a 'clinical' and 'nonclinical' sample. I then go on to describe the method for the main Q methodological phase of this research in which participants were asked to sort a series of statements concerning the experience of depression.

Q methodology allows participants to express their subjective experience while factor analytic statistical methods enable the researcher to uncover the major accounts or experiences (which emerge as statistical factors) conveyed by participants in the sample. In this study each factor will represent some broadly shared experience of depression found among the participants.

4.2 Existential-Phenomenology

In this section I outline my understanding of existential-phenomenology as a broad and multi-layered philosophical movement, and in particular the distinction between descriptive and hermeneutic approaches. I then go on to describe the approach to phenomenological methodology that I take in this research. The term 'phenomenology' – in use from the early 19th century and more fully developed as a philosophical project by Edmund Husserl - denotes a wide range of sometimes fundamentally different approaches to not only philosophy, but also the social sciences, a range of research methodologies, the theory and practice of psychology and psychotherapy and much more. Here I am interested in what is termed existential-phenomenology. Existentialism and phenomenology as two areas of concern can and have been understood as entirely separate; in the mid-20th century there were passionate debates about the relationship between these two areas and whether or not there were, in fact, any commonalities between them at all (Dreyfus and Wrathall, 2006:1). I do not intend to detail those debates here but it is important to acknowledge the complexity of bringing these two areas together and that some philosophers and theorists have objected to this union. However, there are many links between the two movements and many common themes.

Existential-phenomenological approaches all, in one way or another, address questions concerning the structure and meaning of embodied and lived everyday human experience and pose fundamental questions concerning what it means to be human, what it means to exist. Existentialism, as a branch of philosophy, moves us away from a metaphysics of substance and replaces this with a metaphysics of freedom and for some this relates to what Neitschze referred to in his now famous description of the 'death of God' (see Nicolaus, 2011):

> Existentialists are not primarily concerned with human life in general, but with the life of particular existing individuals. They are concerned with human life viewed as a series of decisions and choices, and the first goal is to make us aware of ourselves as living individuals who, in our freedom, make decisions and are responsible for them. (Oaklander, 1996:3)

This metaphysics of freedom signifies a move away from what we might call 'academic' philosophy towards an approach which grounds itself in concrete, embodied, here-and-now lived experience. Moreover, this new approach to philosophy also includes the assertion that existential themes, both in part and in profound ways (through what have been termed existential 'givens'), play a role in shaping other, seemingly unrelated forms of experiencing and knowing. For me, it is important to include here (related to the work of Foucault) knowledge itself, or systems of thought which in turn link to (dominant and subjugated) discourses. In fact, Dreyfus (2004) suggests that there is a rough parallel between Heidegger's central concept of Being and Foucault's central concept of power:

> The history of being gives Heidegger a perspective from which to understand how in our modern world *things* have been turned into *objects*. Foucault transforms Heidegger's focus on *things* to a focus on *selves* and how they became *subjects*. And, just as Heidegger offers a history of being, culminating in the technological understanding of being, in order to help us understand and overcome our current way of dealing with things as objects and resources, Foucault analyzes several

> regimes of power, culminating in modern bio-power, in order to help us free ourselves from understanding ourselves as subjects (Dreyfus, 2004:1).

Dreyfus (op cit) provides many interesting and useful comparisons between these two great thinkers and in particular he emphasises their shared interest in providing a critical space in which we can acknowledge the constructedness of, and think anew, our existence.

Phenomenologists take an interest in the ways, and the forms through which, reality appears to us or manifests itself to us. Rather than assuming that 'real' objects are perceived by a wholly separate consciousness, as with for example a Cartesian understanding (though the early work of Edmund Husserl provided less of a departure in this regard), phenomenologists take an interest in the ways that things are constituted within a field of subjective experience and where personal meaning and significance are a fundamental part of that field. Put another way, what Husserl termed the 'life world' or *lebensweld* (Husserl,1936/1970) is something within which we are fully immersed, and most importantly, rather than the world existing in some kind of objective state that then comes to us through our senses, the 'life world' is always already imbued with meaning, judgements, social and cultural representations and understandings; things have significance to us in varied and complex ways which are not fully reflected in an objectivist version of reality. Thus, here there is an important contrast with scientific and positivist approaches regarding their claim for some kind of objective, material world of facts 'out there' to be discovered through empirical means. There are also links here to a broader philosophical interest in the relationship between how things appear to us and what is real; for Husserl reality always presents itself to us through appearances.

It is primarily Martin Heidegger and Jean-Paul Sartre who have been categorised as both phenomenological and existentialist thinkers although they had very different views about these philosophies. Heidegger always rejected the label of existentialist (see Cohn, 2002) as he believed that existentialism merely persisted with the errors of modernism, whereas Sartre fully and readily embraced it. In the words of Dreyfus and Wrathall, (op cit: 1-2):

> Heidegger's standing in the existential tradition is secured by his exploration of the existential structure of Dasein or human being, his historicised account of essences, his critique of the banality of conformist everyday life, and his reflections on guilt, anxiety, and authenticity… [Whereas] Sartre shared Heidegger's focus on existential, worldly relationships, but sought to account for those relationships in a Husserlian fashion by focusing on consciousness.

4.3 Which Phenomenology?

I now wish to move on to consider the ways in which existential-phenomenology relates to the theoretical framework and research methodology used in this project through a focus on the traditions initiated by Husserl and Heidegger. I then go on to outline some elements of Heidegger's thinking, especially with respect to his observations about mood, which are relevant to this thesis. It is generally accepted that phenomenological approaches can be split into two key traditions; descriptive or transcendental phenomenology (exemplified by the work of Husserl and later championed by Moustakas, 1994 and Giorgi, 2009) and hermeneutic or interpretive phenomenology (exemplified by the work of Heidegger,1962 and his subsequent followers, for example Paul Ricoeur,1983).

Edmund Husserl (1859-1938) is credited with developing phenomenology as a fully-fledged philosophical and methodological framework. He emphasised the need for the detailed, repeated description of lived experience in order to get back to

‘the things themselves’ (Husserl, 1901/2001:168). To enable this detailed description, he devised methods of reduction or epoché, an example of which is eidetic reduction, which is a process of continued imaginative variation of the phenomenon being studied in order to eventually reveal what is essential to its structure. Moreover, for Husserl a central element of the reduction is that in order to gain any access to these essential structures there must be some form of suspension of judgement on the part of the researcher. This did not necessarily entail taking a position of doubt concerning the existence of certain objects in the world but was rather a means to bracket off, to set aside, our judgements and assumptions.

Spinelli (1990: 18-19) summarises the three interrelated steps within Husserl’s phenomenological method as follows:

> Step A: the rule of epoché which ‘urges us to set aside our initial biases and prejudices of things, to suspend our expectations and assumptions, in short, to bracket all such temporarily and as far as is possible, so that we can focus on the primary data of our experience.’
>
> Step B: the rule of description which ‘urges us to remain initially focused on our immediate and concrete impressions and to maintain a level of analysis with regards to these experiences, which takes description rather than theoretical explanation or speculation as its point of focus’
>
> Step C: the role of horizontalisation (the equalisation rule) which ‘further urges us to avoid placing any initial hierarchies of significance or importance upon the items of our descriptions, and, instead, to treat each initially as having equal value or significance’.

For Husserl, the epoché enables the researcher to adopt what he called the ‘phenomenological attitude’ which, as outlined above, consisted of bracketing, or placing to one side, our normal, taken for granted assumptions and values and which operates in contrast to the ‘natural attitude’, which for Husserl is the usual unreflective and assumption and value laden attitude that all human beings adopt in

their everyday lives. Furthermore, in this way, the method of reduction or epoché enables researchers to gradually and methodically gain access to the transcendental elements of human experience. In fact, for Husserl, the terms ‘phenomenology’ and ‘transcendental’ were often interchangeable. Thus, Husserl believed it was possible, through his phenomenological method of reduction, to gain access to the transcendental ego or ‘pure’ consciousness. However, in his later work he moved somewhat away from the idea of the transcendental ego and a consciousness of experience towards what we would now understand as the existential, lived world, (Finlay, 2011). It was Heidegger and others who then took this shift towards the lived world much further and I will return to this shortly.

Husserl’s early focus then, on the ways in which things are constituted within the field of subjective experience, entailed moving away from scientific and positivist claims to provide a more basic or foundational account of the ‘real’ world that we encounter in our experience and perception. For Husserl, phenomenology must always study the life-world as opposed to the objective ‘real’ world brought to us by science. Here he was also drawing from Kant the idea of *a priori* elements within consciousness - meaning that which is presupposed in, and necessary for and to, experience. Furthermore, Husserl suggested that intentionality (and here he draws upon the work of Brentano) was at the heart of human consciousness and for him transcendental phenomenology fundamentally meant a phenomenology of consciousness. Thus, in his model there remains some form of consciousness which in some sense constitutes that which we experience and this is one of the key elements challenged and critiqued by those that followed, especially his most famous student Martin Heidegger.

Heidegger (1889-1976) critiqued and developed Husserl's project in a way that Heidegger described as returning to the fundamentals of the phenomenological project. For Husserl transcendental subjectivity was understood as something which constitutes the subjective fields of significance and meaning whereas for Heidegger this conception of subjectivity did not properly move beyond Cartesian dualism. In this vein, for Heidegger the notion that we are all rational beings is a kind of anthropologism.

Heidegger was interested in the primal nature of Being, the specific ways in which consciousness discloses itself to us. In this way he seeks to account for the underlying nature of Being or Dasein - loosely translated as Being-there, 'human entity' or existence - which offers a way to rethink the 'entity' we understand as ourselves, in a way that releases us from previous conceptualisations and understandings, and in a way which moves beyond the subject/object dualism - where subject and object become rather a 'being-in-the-world'. It has been suggested that one useful way to understand the difference between the work of Husserl and Heidegger is that while Husserl's was an epistemological project, where the cogito remains intact, Heidegger's project was ontological, he was concerned with understanding Being itself, asking the question; what is Being? (Phillips, 2014: 611). Thus, Heidegger seeks to *begin* with the question of Being, as fundamentally that which comes into being precisely because Being is an issue for us, '[Dasein is] that entity which in its Being has this very Being as an issue…' (Heidegger, 1962: 68).

Heidegger suggests that we are 'thrown' into the world - this of course is not something we choose - and that Dasein is not only 'being-there', but also and fundamentally a being-there-with-others or 'Being-with' (Heidegger, 1962: 149).

Moreover, ‘thrownness’ not only leads Dasein to be-with-others, but also constitutes Dasein in its temporality because, just as we are thrown into life, into existence, we are also at the end of our lives thrown out. We are then, in Heidegger’s words, a Being-towards-death. Crucially, it is death, through our projecting ourselves into the future and anticipating death or non-being, knowing that our lives are finite, that makes time itself meaningful for us. In this way Being, life, death and time are all ontologically intertwined. Furthermore, for Heidegger a self-consciousness always exists *for* another self-consciousness and this links to Hegel’s dialectic of recognition. Drawing on this, Heidegger suggests that mutual recognition is a condition of possibility for Dasein. Thus, the mutual recognition which is a fundamental part of Dasein’s Being-there-with-others is central to our understanding of death and temporality, as Osborne illustrates:

> …as a self-interpreting, self-conscious being, Dasein’s individuality cannot be derived from its anticipation of death independently of its relations with others. Rather, Dasein must first, or simultaneously, be constituted as a self-conscious being through its relations with others, in a dialectic of recognition, in order that it may become the kind of being which is capable of anticipating its death as the end towards which it is thrown, and hence of constituting itself existentially as a Being-towards-death.’ Osborne (1995:70)

In this way death makes existence an issue for us, death gives us existential awareness or put another way, ‘it is recognition which “temporalises” time’ (Osborne, op cit: 80).

4.4 Heidegger’s understanding of mood

For Heidegger, Dasein can be compared to a clearing (something like a clearing in the forest or the woods), as that which discloses the world to us, ‘Dasein is its disclosedness essentially’ (Heidegger, 1962: 263), however the question of what Heidegger means by this and what it is that Dasein discloses is in fact complex not

least because Heidegger said different things about this issue (Haugeland, 1992). However, here I wish to focus on Heidegger's understanding of emotion and of particular relevance for this study of depression is Heidegger's notion of mood as a fundamental aspect of how we find ourselves (how the world is disclosed to us) and as contributing to the sense we have of belonging to a world. A mood 'comes neither from "outside" nor from "inside", but arises out of Being-in-the-world, as a way of such being', *(*Heidegger, 1962*:* 176). Thus, Heidegger's understanding of mood is not synonymous with the way we would normally use the term - to mean a generalised affect - as Ratcliffe (2013b: 159) further elucidates:

> A mood, for Heidegger, does not add emotional colour to pre-given objects of experience. We can only have objects of experience insofar as we already find ourselves in a world, and we would not find ourselves in a world at all without mood. For the same reason, a mood is not a generalised emotion.

Cohn (2002) points to the difficulties in translating the two key terms that Heidegger uses in this area of emotion; *Befindlichkeit,* literally meaning how we find ourselves and which Cohn (op cit) suggests best translates as 'attunement' and *Stimmung* which translates as something like 'mood' or 'feeling' (Cohn, op cit prefers the latter). Others have translated *Befindlichkeit* as 'disposition', 'situatedness', 'affectedness', 'so-foundness' and these different translations give a sense of both the complexity of what Heidegger means by this term and the difficulty of translation to English given Heidegger's complex vocabulary. However, what is perhaps most relevant here is the relationship between these two concepts. For Heidegger 'attunement' (*Befindlichkeit*) is existential (or ontological) and is expressed ontically as our everyday 'feeling' (Stimmung):

> What we indicate ontologically by the term "state of mind" [*Befindlichkeit*] is ontically the most familiar and every day sort of thing; our "mood", our Being-attuned. (Heidegger, 1962: 172)

Thus Heidegger offers a way to understand what is underneath our everyday feelings and the way those feelings are inextricably linked to our situatedness; where our feelings are always bound up with the way we find ourselves in the world:

> [Dasein]… always finds itself already situated; being in the midst of things is being, in each case, already in some definite situation. The expression "finds itself" is Heidegger's. With it he is clearly adverting to the constitutive item in being-amidst that he calls *Befindlichkeit*: that essential character of living Dasein that, in each case, it always finds itself already situated. (Haugland, 1992:37)

Heidegger's notion of *Befindlichkeit,* I argue provides an important alternative understanding to the established clinical and psychological accounts of feelings and mood, one in which it is possible to get beneath the lived experience, to get to something deeper, something existential, that is to begin to consider the ontological, existential aspects of sad mood and depression. Ratcliffe (2013b: 157) offers a further useful exposition of Heidegger's use of this term *Befindlichkeit*:

> Being in some mood or other is, according to Heidegger, a fundamental "existentiale" of Dasein. In other words, it is essential to the distinctively human way of having a world… In the absence of mood, we would not find ourselves in a world at all and would therefore cease to be Dasein. Heidegger refers to the characteristic of finding oneself in a world through a mood as "Befindlichkeit", a notoriously difficult term to translate.

In order to more fully understand this notion of finding oneself in a world through a mood it is also important to consider Heidegger's description of what he called 'care' or 'concern' (*Sorge*) as a primordial state of Being, as 'the structure of Dasein itself' (Heidegger, 1992: 293). Heidegger posits three basic elements of existence or *existenziale*; *Befindlichkeit*, *Verstehen* (usually translated as understanding) and *Rede* (usually translated as discourse) which are all interrelated

and should not be separated out from one another. This tripartite structure of care (*Sorge*) alerts us to the ways in which mood, understanding and discourse need to be understood together in order to move towards a deeper, existential understanding of our feelings and emotions. Thus, Heidegger's understanding of emotions as always bound up with situations, or in other words that 'feelings belong to the 'Da' of 'Sein', to the 'there of Being' (Cohn, 2002: 61), might shed further light on what it means to be depressed and what a depressed mood discloses to us. In the words of Polt (1999: 66 cited in Cohn, op cit: 61) 'they [feelings] show us things in a more fundamental way than theoretical propositions ever can'. In this way, Heidegger's conceptualisation of emotions may enable an analysis of the existential (ontological) elements of depressed mood that provides one possible alternative to the established, mainstream psychological and medical models. Indeed, depression, particularly severe depression, would seem particularly apposite as a form of mood in which the world appears changed in a deep and profound way, as Ratcliffe, (2013b: 261) suggests:

> …[A]lmost every account of severe depression includes references to changes in mood or feeling that are inextricably bound up with profound alterations in how one finds oneself in the world. For some, the possibility of encountering things as mattering in certain kinds of way is altogether gone from experience. People often report that all sense of practical significance has vanished and, alongside it, a sense of the potential for emotional connectedness with other people.

Thus Heidegger's notion of Dasein, along with his related concepts of care and the way that mood and emotions are fundamentally bound up with this structure, is something that may shed light upon, and help to further explicate, participants' experiences of depression. I return to these concepts later in the thesis.

4.5 Personal reflection

For me phenomenology is something that I had been aware of in my academic work for some time, particularly as a crucial area of philosophy and theorising which preceded structuralism and post structuralism, but until recently it remained an approach that I had not engaged with at a deeper level. Of late, I came across phenomenology through my teaching of qualitative methods and in particular my teaching and project supervision involving Interpretive Phenomenological Analysis (Smith, Flowers and Larkin, 2009), which is becoming increasingly popular in psychology, especially health psychology. Much IPA research always seemed to me to have a very thin, watered-down version of phenomenology which seemed only to add on a minimal engagement with reflexivity (a kind of reflexivity which, in any case, is typical of much qualitative work in Psychology), adding a 'double hermeneutic' to, in practical terms, a method of doing qualitative analysis which seemed to me to be fundamentally straight forward thematic analysis.

However, my reading and my classes for my DCPsych course have enabled me to learn much more about phenomenology and to try to better understand the way in which it fits into 20th-century theorising and philosophy and in particular recent critiques of mainstream psychology. As I have read in the area and conducted my research for this thesis I have come to understand that much of my work and teaching to date, especially my understanding of qualitative methods in psychology, was already profoundly shaped by phenomenology and, without naming it as such, I had been teaching some phenomenological ideas for some time. I now have a deeper sense of the complexity and utility of this approach and this experience has, in some way, felt like a kind of returning 'home'.

I also want to say something about my feelings concerning Heidegger's links to Nazism. It is clear to me that Heidegger's association with, and personal views about, Hitler and National Socialism are complex and difficult to fully ascertain. While there appears to be contradictory evidence about the extent to which he personally supported Hitler's regime, it is beyond doubt that Heidegger was a member of the Nazi party and that there is evidence that he, at the very least outwardly, participated in the party and in the anti-Semitism of the time. Furthermore, some of his speeches and actions were ambiguous in this regard to say the least. My own feelings about this issue are mixed. On the one hand I fully understand those academics and practitioners who will not engage with Heidegger's work on principle because of his Nazi past, and on the other I can see that the form and meaning of his Nazi associations are somewhat opaque and difficult to conclusively define. For me his work is of such importance that I wish to engage with it and to learn from it, however I can never shake my uneasy feelings about this issue and continue to read his work with ambivalence and anxiety.

4.6 What about the truth?

Finally, I wish to consider the issue of the extent to which psychological (including counselling psychology) research can or should be understood as providing an account that we might take to be true, or to represent the 'real' world in some way. My own long-standing way of making sense of the issue of truth and reflexivity in relation to psychological research has been through the idea of an opposition between truth and representation, where representations and the ways these circulate in our cultures both provide possibilities for and at the same time place limits upon our understandings and experiences. For me, all research produces particular kinds of representations which may be taken to be true, or have some kind

of truth value applied to them, however we can never have unmediated access to some form of absolute truth, in the words of Edward Said:

> 'the real issue is whether indeed there can be a true representation of anything, or whether any or all representations, because they are representations, are embedded first in the language and then in the culture, institutions, and political ambience of the representor. If the latter alternative is the correct one (as I believe it is) then we must be prepared to accept the fact that a representation is *eo ipso* [by that very act] implicated, intertwined, embedded, interwoven with a great many other things besides the 'truth', which is itself a representation, (Said 1979: 272-273).

For Heidegger phenomenological method is always interpretive, moreover he argues that there is never pure description but rather description is always in some sense already interpretation. Thus, from a Heideggerian position research must always be seen as an interpretation, transcendental consciousness is never possible and our research findings must be seen as a product of both that which is studied and the person, the Being, that studies it. Finlay (2008: 3) provides a useful threefold account of the issue thus:

> First, hermeneutic phenomenologists argue that any description of lived experience by participants has to be seen in the context of that person's life situation and projects… Secondly, interpretation is further implicated as researchers empathise with, and make sense of data by drawing on their own understandings (which arise out of their life experience). Thirdly, interpretations are filtered through a spatial-temporal lens and arise out of particular cultural and historical fields… We cannot help but bring ourselves into the research.

However, it is important to remember that Heidegger's account of truth is very different to the social constructionist/post-structuralist notion of truth as representation or as an effect of discourse. For Heidegger, truth is understood as 'aletheia' – as something that is disclosed or unconcealed. 'Aletheia' is not equivalent to a notion of correspondence or accuracy but rather describes the disclosure of Being, and this operates at the ontological level. Therefore, the kinds of

representational and discursive processes described in social constructionism would only be possible *because of* this unconcealment of Being, which is more elemental or foundational to existence and lived experience. A full account of the complex and interesting differences between the work of Heidegger and the social constructionist perspective(s) outlined earlier is beyond the scope and remit of this thesis, however it is important to acknowledge these sometimes fundamental differences and that bringing the different approaches together is not without its difficulties and limits.

Given this, I primarily take a social constructionist approach to truth in this project which acknowledges the very fine line between description and interpretation, however I also take on board Heidegger's notion of 'existential truth', or a 'lived/living truth', which I return to towards the end of the thesis. For me there can never be such a thing as pure description, by definition any description is always already an interpretation. Moreover, our interpretations are made possible through not only our personal experiences but also and perhaps primarily through the social and cultural meanings (representations) that exist (and which we have internalised, introjected) at any particular time. It is those social and cultural meanings which operate through the discourses that we draw upon in order to make sense of ourselves, others and the world around us. Without an acknowledgement of this we are unable to meaningfully account for the (historical) limits which form the horizon of what it is possible to say, to think and to do.

Chapter 4 (Part 2): Methods

4.7 Introduction

In this second part of the chapter I present a detailed description of the two methods that were used in this project. Of these two, thematic analysis - adopted for the preliminary focus group phase of data collection - clearly falls under the rubric of qualitative methods. However, the second method, Q-methodology, combines elements of both qualitative and quantitative approaches.

The first phase of this research consisted of a preliminary study of a small but diverse sample of participants who had experienced depression either currently or at some point in the past (or both). Two focus groups were conducted which were subsequently qualitatively coded (using thematic analysis) and the results were incorporated with other sources and a wide range of literature for the development of materials (statements) for the main study. This second, principal, phase of the study utilised Q-methodology where 46 participants were asked to sort (online) a series of 58 statements concerning the experience of depression, placing these statements along a continuum ‘most like me when I’m depressed’ to ‘least like me when I’m depressed’. The Q-sorts can then be factor analysed (person by person) to reveal a number of factors, each of which represents a common experience of depression within the sample.

In relation to methodology, as I’ve already indicated in part 1, while this research utilises an existential-phenomenological framework to situate and make sense of what participants tell us, overall I take a social constructionist perspective to this thesis which, for me, offers a useful way to question and to problematise many

taken for granted aspects of more mainstream (often quantitative) methods and approaches within psychology and counselling psychology.

4.8 Phase 1: Method for preliminary focus group study

4.8.1 Design

The initial data collection phase of this research involved a small scale qualitative exploration of participants' self-reported experiences of depression. This preliminary study deployed focus groups to collect qualitative data which was subsequently analysed using thematic analysis (please see details below). Two focus groups (with a total of eleven participants) were conducted with visual stimuli (a range of images of depression, please see Appendix 2 for examples) used to elicit as much personal description (and group discussion) as possible from participants concerning their experiences of depression. The key aim was to uncover as full a range as possible of descriptions of this phenomenon so that these could contribute to the preparation of materials used for constructing the final Q-sample (statements).

4.8.2 Participants

11 participants were recruited through purposive and snowball sampling, aged 26-48, average age 33. All participants were required to have self-identified as having experienced depression at some point in their lives. For the purposes of this study, two contrasting groups were identified, one where participants had not been treated for depression or any related condition, and one where all but one participant had been treated. The first group was composed of persons who had experienced mild to moderate depression and the second group was composed of persons who had experienced severe depression. In this way each group was fairly homogeneous in terms of perceived severity of depression and 'clinical' versus 'non-clinical'

experience – which here I define as having been professionally diagnosed and/or treated in some way now or in the past for depression or a related disorder.

Group one was recruited through a contact of the researcher and comprised a group of work colleagues (Marketing professionals) and group two was recruited via a social network site, Facebook. Most of the participants in group two did not know each other although two did have a relationship (siblings). Group one was predominantly male, group two was more mixed but was predominantly female.

Table 4-1 Participant demographics for the focus group research

Focus Group 1 (mild-moderate depression/'non-clinical')

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Treated for depression?*	*Prescribed anti-depressant medication?*
1	Male	48	White/British	No	No
2	Female	48	Indian	No	No
3	Male	43	British/Pakistani	No	No
4	Male	32	British/Asian	No	No

Focus Group 2 (severe depression/'clinical')

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Treated for depression?*	*Prescribed anti-depressant medication?*
1	Female	27	White/British	Yes	Yes
2	Female	26	Mixed Race/French	Yes	Yes
3	Male	29	White/British	No	No
4	Female	26	White/Irish	Yes	Yes
5	Female	30	White/British	Yes	No
6	Male	26	White/Australian	Yes	Yes
7	Female	31	White/British	Yes	Yes

4.8.3 Materials

A focus group protocol was designed (see Appendix 2) drawing upon reading and research in the area and in line with established focus group practice (Bloor, Frankland, Thomas and Robson, 2002; Morgan, 1997; Puchta and Potter, 2004). Thirty-five pictures were sourced from the internet using Google Images. These

pictures were all elicited using the key words ‘depression’ and ‘depressed’ and the researcher selected a range of pictures which gave a wide coverage of available images - having surveyed a large number of images from this source. Several example pictures are given in Appendix 2. Other materials included an information sheet, participant information questionnaire, consent form and debriefing information sheet (all can be found in Appendix 1).

4.8.4 Procedure

Both focus groups took place at the University of Westminster in central London. Participants were asked to carefully read the information sheet before the group discussion and had also been given this information prior to attending. Participants were then asked to complete the consent form and the participant details questionnaire and were reminded that participation is fully confidential. After introductions and a warm up exercise the researcher briefly explained that the main research interest was looking at experiences of depression which had lasted more than 2 weeks (roughly following the DSM-5 diagnostic criteria of two weeks minimum duration). Following a warm up exercise participants were asked to select one or more images as follows: ‘Choose an image or images that represent a sad, depressed feeling (or feelings) you’ve experienced or are experiencing now’. Participants were then asked – each in turn – to explain their choice of picture(s) and to tell the group something about the feelings and events they felt the picture(s) represented. Once all participants had talked about their pictures, a more general discussion was facilitated by the researcher. At the end of the discussion participants each – in turn – stated how they were feeling at that moment and were asked to identify something positive that they would take from the group. Participants were then given the final debriefing information sheet to take away with them.

4.8.5 Analysis

The data was analysed using thematic analysis (Braun and Clarke, 2006; Boyatzis, 1998; Patton, 1990; Tuckett, 2005) and taking a 'semantic' approach (Braun and Clarke, 2006: 13). The analysis was conducted in six phases (adapted from Braun and Clarke, op cit: 16); 1) transcription of the data, 2) reading and familiarisation with the data, 3) generating initial codes, 4) searching for themes, 5) reviewing themes, 6) defining and naming themes. However, there was an additional step (between 5 and 6) where the themes from the two groups were combined so that the final themes reflected experiences from both groups. In this way, a more detailed, in-depth understanding of the experiences of participants was assembled in a form suitable to contribute to the subsequent construction of the Q-sample (for an overall summary of themes, please see Chapter 5).

4.9 Phase 2: Q Methodological study

4.9.1 Design

An analysis of the lived experience of depression requires a method that assumes no a priori definition and therefore – in terms of data collection - imposes no prior conceptual framework (for example in the form of a hypothesis) upon the experience to be studied. I will now outline the origin of Q-methodology and describe its operation in more detail.

Q methodology, developed by Stephenson (1935), is a statistical technique which allows the emergence of each participant's particular interpretation, understanding or experience. In terms of procedure, Q methodology is very much a quantitative (factor analytic) technique, however Stephenson reversed the usual way in which factor analytic techniques had been used, up until then, within psychology.

This reversal, which was in fact an inversion of the existing R-methodology (the usual way of using factor analysis in psychology which correlates participants' responses to scale items/questions), makes Q methodology very different to other factor analytic techniques and procedures normally used within psychology. In Q methodology, persons rather than items are correlated, so that the emerging factors represent shared experiences and understandings rather than internal psychological characteristics or essences. In this way Q methodology is somewhat radical in its approach within psychology prioritising as it does, lived experience over theoretical, often essential constructs. McKeon (1990: 28) describes the significance of Stephenson's new approach:

> The method's origins can be traced to a brief letter Stephenson published in *Nature* 1935 in which he proposed applying factor analysis to persons rather than to traits. By way of this "inverted" use of the technique… Stephenson was advancing a new concept as well as a different employment of a powerful statistic.

William Stephenson (1902-1989) was trained in physics at Oxford and Durham universities and gained his PhD in this field in 1926. He then went on to study psychology and psychometrics at University College London under Charles Spearman, and while he was there he also worked with Cyril Burt. In 1929 Stephenson completed a second PhD this time in the field of psychology. Throughout his career Stephenson sought to marry the scientific rigour, that was such a central aspect of academic psychology at that time, with an approach to subjectivity that properly enabled participants' own experiences and viewpoints to come to the fore - in a way that was far less shaped by or, for some, distorted by the subjectivity and viewpoints of the researcher. In this sense while Q methodology is fundamentally quantitative in nature, drawing upon factor analytic statistical techniques originally pioneered by Charles Spearman, its broader methodology fits

better with current qualitative approaches to psychology. The somewhat more contemporary aim that participants' lived experiences should be central to qualitative psychology is very relevant here, where respecting difference and giving voice to participants is seen not just as a methodological requisite (Larkin, Watts and Clifton, 2006) but also as an ethical and political strategy (Stainton-Rogers, Stenner, Gleeson and Stainton-Rogers, 1995).

Q methodology enables participants to make their own sense of the 'items' (in this case a series of statements concerning the topic or experience in question), so that participants, through the act of sorting statements, are able to more or less represent their own personal experience and understanding. Steve Brown, (1980: 3) - probably Stephenson's best-known student - makes the case for enabling participants to convey their own subjectivity in this way:

> Language-in-use is by its nature symbolic and self-referential, with each combination of words being capable of carrying a wide range of meanings. For an investigator to regard his own understanding as in some sense objective or correct is therefore pretentious in the extreme.

Thus Q methodology, while on the one hand utilising rigorous and powerful statistical techniques, on the other hand can accommodate the many possible ways that participants can bring their own personal experience into focus. This is in stark contrast to established psychometrics where the meaning of items, for example in a psychological scale, is predetermined by the researcher and their theoretical stance. Brown, (1980: 3) goes on to remind us that:

> When a subject responds to a scale item… the meaning and significance his [sic] response has for him may differ in major respects from the meaning assumed by the Observer or anyone else, and to ignore this possibility is to be unwilling to accept what is before one's eyes, to be aspect blind, and to prefer the artificial to the natural.

Thus, Q methodology eschews the hypothetico-deductive methodology of mainstream psychology and provides an inductive method for understanding participants' subjectivity, or more precisely their self-reference. Stephenson (1980: 8) himself emphasised the element of discovery with regard to his technique; 'what is involved is the discovery of hypotheses and reaching understandings, instead of testing hypotheses by way of predictability and falsifiability.' Thus, in contrast to R-method, here the concept/topic/phenomenon in question is assumed to have no meaning apart from the respondent's self-reference,[6] that is Q-method is a method of 'impression' as opposed to 'expression' (Beeb-Center, 1929). With methods of expression (R-methods), participants are measured for traits, attitudes and so on as if they 'resided' within the individual as (measurable) essences. Q-method however, as a method of impression, allows the individual to assign their own meaning to the research question in terms of her or his own frame of reference. Q-method then, allows the individual to make their subjectivity operant (Brown, 1980; McKeown and Thomas, 2013; Watts and Stenner, 2012).

While Q-method has been utilised with a range of conceptual frameworks such as discursive, narrative and other qualitative methodological approaches, I wish to utilise it as a phenomenological research method. Shinebourne and Adams (2008: 103) have argued - following a study of the attitudes, beliefs and experiences of therapists working with clients with problems of addiction – that Q-methodology:

> …can make a contribution to expanding the repertoire of phenomenological research methods available to psychotherapists…Q methodology is particularly suitable for identifying commonality and

[6] It should be noted that Q-method attaches no truth value to the 'voice' articulated by the participant, it assumes that each of us has access to many different voices or 'texts'. In this study I would ascribe participants' experiences the status of subjective truth but would not assume that this truth is necessarily fixed or unchanging.

diversity and has a powerful capacity for thematic identification and analysis.

4.9.2 Participants

Q-method requires a highly diverse person sample (P-sample) so that participants reflect a wide range of demographic variables in order to ensure inclusion of as many different experiences as possible. Forty-six participants (a sample of 40-50 is usually recommended for most Q studies), aged between 19 and 83 (mean age = 44.2, SD = 13.90) were recruited using a variety of methods, including personal and professional contacts (using snowballing), my placements, and a dedicated Facebook page. Ethnicity was not purposively sampled for and accordingly the sample was predominantly White/British with some White Welsh/Irish. There were also some participants identifying as Black and Asian/British and a small number of participants from Europe and beyond. Only participants who self-identified as having experienced depression currently or in the past were sought. Sampling aimed for diversity, such that as broad as possible a range of demographic variables could be achieved, including age, severity of depression, whether or not diagnosed and a rough balance between genders. Demographic variables were recorded in confidence.

Of the forty-six participants, 28 (61%) were female and 18 (39%) were male. 23 (50%) had been diagnosed with a depressive illness and 17 (37%) were either currently taking medication or had done so in the past. In terms of severity, 15 (33%) self-identified their depression as mild, 19 (41%) as moderate and 10 (22%) as severe (2 [4%] did not give any information in this regard).

Table 4-2 Participant demographics for Q-methodological study (denotes author's Q-sort)*

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Ever diagnosed?*	*Self-identified severity*	*Prescribed anti-depressant medication?*
1	Male	39	Spanish	Yes	Severe	No
2	Female	40	White/British	Yes	Moderate	Yes, in the past
3	Male*	50	White/British	No	Mild	No
4	Female	49	White/British	Yes	Moderate	Yes, in the past
5	Male	50	White/Welsh	No	Mild	No
6	Female	21	Indian	No	Moderate	No
7	Female	48	White/Irish	Yes	Moderate	Yes, currently taking
8	Female	49	White/British	Yes	Severe	Yes, currently taking
9	Female	26	Black/British	No	Moderate	Yes, currently taking
10	Female	48	Polish	No	Mild	No
11	Female	29	White/British	Yes	Moderate	No
12	Female	35	Black/British	Yes	Moderate	No
13	Male	45	White/British	Yes	Severe	Yes, in the past
14	Female	36	White/British	Yes	Moderate	Yes, in the past
15	Female	47	Black/British	Yes	Severe	Yes, in the past
16	Female	44	White/British	Yes	Moderate	Yes, in the past
17	Female	59	White/British	Yes	Moderate	Yes, currently taking
18	Male	46	White/British	No	Mild	No
19	Male	45	White/British	Yes	Moderate	Yes, in the past
20	Male	48	White/British	No	Mild	No
21	Female	58	British/ Malaysian	No	Mild	No
22	Female	47	Brazil	Yes	Moderate	Yes, in the past
23	Male	46	White/British	No	Mild	No
24	Male	29	White/British	No	Moderate	No
25	Female	29	White/British	Yes	Moderate	Yes, currently taking
26	Female	45	White/British	Yes	Moderate	No
27	Female	None given	None given	None given	None given	None given
28	Male	47	None given	None given	None given	None given
29	Male	36	White/German	No	Severe	No
30	Female	19	White/British	Yes	Moderate	Yes, in the past
31	Female	48	White/British	No	Mild	No
32	Male	52	British/Asian	No	Mild	No
33	Male	50	White/British	No	Mild	No
34	Male	67	White/British	Yes	Mild	No
35	Female	57	White/British	No	Mild	No
36	Female	24	White/British	Yes	Severe	Yes, in the past
37	Male	58	White/German	Yes	Moderate	No
38	Female	83	White/British	No	Mild	No
39	Female	71	White/British	Yes	Mild	No
40	Female	28	Egyptian	No	Mild	No

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Ever diagnosed?*	*Self-identified severity*	*Prescribed anti-depressant medication?*
41	Male	27	Black/British	Yes	Severe	No
42	Female	42	British/Asian	No	Severe	No
43	Female	44	White/British	Yes	Moderate	No
44	Female	71	White/Welsh	No	Severe	No
45	Male	25	White/British	No	Moderate	No
46	Male	31	White/British	No	Severe	No

4.9.3 Materials

For Q-method to elicit the fullest range of experiences within the sample it is important that the statements which the participant sorts (called a Q-sample) are representative of as many of the prevailing experiences or discourses as possible. Thus the Q-sample must broadly represent the wider array of whatever it is possible to say about a particular topic or experience, and Stephenson (1978) called this the concourse. Thus one key task in a Q-methodological study is to produce a Q-sample (or Q-set) from the wider concourse in an organised and methodical way. For Stephenson any concourse will obey the role of finite diversity, meaning 'that whenever and wherever persons are applied to a sample of elements [this] results not in chaotic proliferation but in the expression of several ordered patternings of… understanding (Stainton Rogers, 1995: 180). Sampling from the concourse requires careful and detailed collection and analysis of the available accounts, understandings and experiences, in this case relating to what it is like to feel depressed. This stage of the research requires a great deal of time and effort on the part of the researcher. (Stainton Rogers, op cit: 186) describes the process thus:

> This stage of a Q methodological study does not look unlike a structural analysis, or the proper ground work to the generation of questionnaire items, or, indeed, some form of discourse analysis. Many of the same craft skills hold. Open-ended material is sifted, ordered, condensed, to yield a representative pool of propositions.

Thus, the Q-sample was constructed through close reading of a wide range of relevant academic and popular literature and other sources (for example autobiographical accounts, some of which are presented in the literature review in chapter 3), as well as the results from the preliminary focus group study, so that the Q-sample included as many of the relevant experiences and issues as possible. Nine statements were also produced based upon the diagnostic criteria for major depression in DSM-5, so that these statements could be sorted alongside the others, please see Appendix 4 for these statements.

To produce a viable sample of representative statements for the study, the following procedure was adopted:

- A wider sample of approximately 400 statements concerning the experience of depression was drawn from the range of materials described above.
- These 400 statements were then grouped under 14 emergent themes where the number of statements for each theme was also noted.
- All 14 themes identified above were included as the basis of the final Q-sample where each theme included a number of statements which roughly represented the frequency of occurrence of statements/themes in the original sample.
- The statements were then continually refined and edited for readability and comprehension to produce 58 statements with all 14 themes represented (please see Appendix 4).

4.9.4 Procedure

Q-method requires each participant in the sample to sort a series of statements into a particular order/pattern that reflects that person's experience of the question or topic under investigation. No definition of the experience is assumed beforehand but is inferred from the location of the statements sorted by the respondents, as she or he distributes them along the Q-sort continuum. For this study the statements were rank ordered from 'least like me when I'm depressed' (-5) to 'most like me when I'm depressed' (+5). This means there were 11 columns including the zero column which was available for participants to place items that they felt ambivalent or unsure about, or where they did not understand the meaning. The following grid was used for participants to arrange their statements:

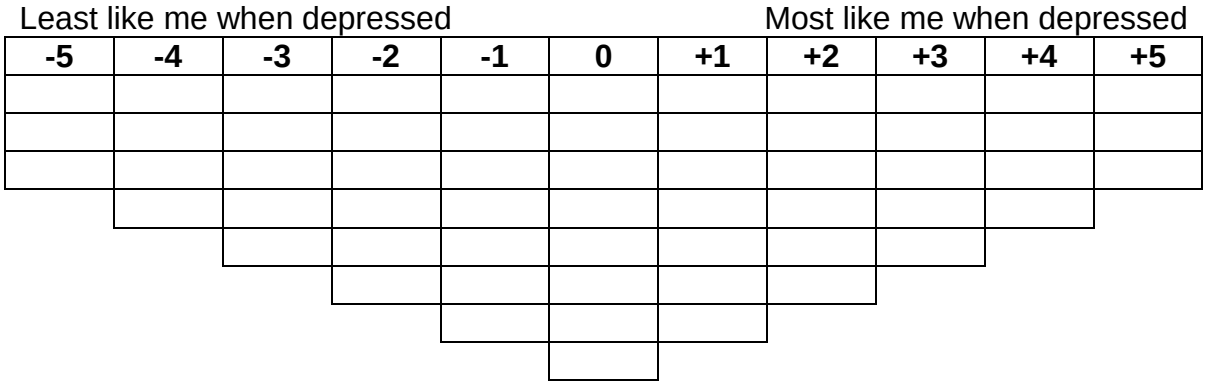

Figure 4-1 Q-sort grid with sort values for each column

An HTML software package was used to present the Q-sort (HTMLQ version 1.0.0) so participants were able to complete the sort on-line. This programme presents statements in random order and participants are asked firstly to sort the statement into 3 piles; 'least like me when I am depressed', 'most like me when I am depressed' and 'neutral/unsure/ambivalent'. Participants then place the statements onto the grid, one pile at a time, and can change the placement of any statement as many times as they wish until they are happy with their sort. Once the sort is

complete participants are then asked to describe why they placed the statements in the ‘5’ and ‘-5’ columns and there is also a space for any additional comments. The arrangement of items in each Q-sort is then compared with the arrangement of every other Q-sort in the sample using factor analysis so that the emergence of orthogonal factors is evidence of different experiences in the sample; an individual’s positive loading on a factor indicating his or her shared subjectivity with others on that factor.

4.9.5 Analysis

Once the data had been collected, the placement of each statement for each individual Q-sort (in numerical form) was entered into a specially designed statistical programme (PQMethod version 2.35). The data were then factor analysed using the Principal Components technique and then programme rotated (as opposed to hand rotation) using the Varimax facility in the software. The Principal Components analysis automatically produces eight factors and all eight of these factors satisfied the criteria for going forward to rotation (having an eigenvalue of 1 or above). Once the rotated factors have been produced a decision must then be made concerning which of these factors is interpretable (I present the details and results of this process in Chapter 6). Once the calculations and factor selection procedures have been performed the programme produces a data file which includes a table of all factors showing each participant’s loading, and marks where any loading is significant, (see Appendix 5). The programme also provides factor arrays for each factor showing the placement of all statements for each factor, which are then used to interpret the factor along with any comments participants have given regarding the statements they placed in the +5 and – 5 columns. In addition, statements which are sorted in significantly different ways for each factor (distinguishing statements) and

statements which are sorted similarly for each factor (consensus statements) are also reported which, in turn, are used as part of the process of interpretation.

4.10 Validity of phenomenological research

Issues of validity need to be thought about in different terms for phenomenological research compared with other psychological methods, given that this approach takes a more complex and nuanced stance on the nature of truth and objectivity, including the role and effect of the researcher's own subjectivity. Rather than validity being judged in terms of correspondence to some real or actual facts, objects or events, here validity is understood in terms of other concepts, such as applicability, transparency, coherence and fruitfulness. Finlay (2011: 264-265) suggests the following four evaluation criteria (which she terms the 'four R's') for phenomenological research:

> Rigour: has the research been competently managed and systematically worked through?
>
> Relevance: concerns the value of the research in terms of its applicability and contribution.
>
> Resonance: taps into emotional, artistic, and/or spiritual dimensions which can probably only be judged in the eye of the beholder.
>
> Reflexivity: is a broad category which refers to the researcher's self-awareness and openness about the research process.

I have endeavoured to fulfil all these criteria while conducting this research, however readers must ultimately decide on the extent to which they feel these criteria have been satisfied.

4.11 Ethics

This project operated at all times within BPS ethical guidelines and was given prior ethical approval from the NSPC ethics committee. All participants were fully briefed

and de-briefed and required to give full consent to participate. Participation was fully confidential and the identities of participants were protected at all times. Participants were able to withdraw from the study at any point and were given a debriefing information sheet concerning depression after taking part which included signposting to services, websites and self-help groups. Participants were also able to contact the researcher (myself) at any time if they had questions or concerns. A summary of the research findings - upon completion of the project - was also made available to participants on request. Likewise, focus group participants were able to request a copy of their transcript.

With regard to the focus groups, the sensitive nature of the topic was partly managed through the way the group discussions were structured. The protocol included a gentle warm up exercise and the use of visual stimuli to help participants share their experiences. The groups finished with participants sharing their final feelings about the group and any positive aspects of the experience that they would take away.

For me, the ethical duty of care in research and in psychological practice not only concerns abiding by certain professional values and standards, but more importantly is reflected in my personal conduct and the individual stance I take towards participants and clients. It was crucial for the success of this study that participants trusted me enough to share their often deeply personal and sometimes very painful experiences and life events. I do not believe that such trust can be created through any formula or solely through abiding by certain rules, rather I had to be open and honest with participants - where for example they contacted me with questions about the study prior to participating – so that they were able to see who I

am, how I work and how I understand and make sense of depression and mental health more generally. This, for me, is just as important, possibly more important, than the practical issues, for example fully briefing participants on the nature of the task they are being asked to undertake. As with so much of this work, ethics is essentially personal and it always feeds in to the relationships we create in our research and through our work as practitioners.

Chapter 5 Results of preliminary focus group study

5.1 Introduction

In this chapter I present the results of the preliminary study which involved collecting data using two focus groups. I begin with a general summary of the group process and the main issues and experiences raised in each of the two groups and then go on to present four related higher order themes that emerged from the thematic analysis.

5.2 Overall description of focus groups

Group 1 was a smaller group (four participants) comprised of three males and one female. No one in this group had experienced severe depression or ever been treated for depression or a related condition. As the facilitator I had to take the lead in enabling the (male) participants to talk about their feelings and in fact overall there was less discussion of how depression feels in this group. Towards the end of the session there was a general consensus that ‘real’ depression (as something deeper, more profound and longer term) was not something anyone had experienced but rather they had experienced feeling ’very low’, feeling ’overwhelmed’. Depression felt ‘stuck’, ‘lonely’, ‘heavy’, ‘black’, isolated’, lacking in hope and related to hiding away and shutting people out. There was a strong emphasis on losing and gaining motivation, taking action, taking control and getting things done. Being active in changing one’s thinking and problematic situations were seen as key means of ‘digging’ oneself out of depression. Overall, this group gave a snapshot of what might be termed non-clinical, everyday depression.

Group 2 was a larger group (seven participants) comprised of two males and five females. All members of this group had experienced severe depression and all

but one had been treated for depression or a related condition. Three participants had been prescribed medication for depression or a related condition. As the facilitator I had a much easier task with this group who after the initial warm up and discussion of chosen images were very keen to share their experiences with me and each other. With this group there was a great deal of talk about the feelings associated with depression and a rich picture emerged of what depression is like for the group along with how participants made sense of this experience. Depression here felt ‘heavy’, ‘frustrating’, ‘isolating’, ‘ambiguous’, like a ‘deep hole’, a ‘black hole’, ‘stuck’, ‘difficult to vocalise’, ‘self-conscious’, ‘confusing’, ‘indulgent’, ‘not understood’ and something to hide or cover up. There was a strong emphasis on the difficult and painful aspects of the experience including dealing with and anticipating the often unhelpful reactions of others. There was also an emphasis on depression as something which might recur, something participants had to learn, over time, to live with and to accept. Overall, this group seemed to represent a snapshot of a more ‘clinical’ type of depression.

5.3 Results/themes

From the thematic analysis, four related higher order themes emerged which I have represented diagrammatically below. Please also see the table of themes in Appendix 3 and sample transcripts in Appendix 6. All themes are fully interrelated. I describe each theme in more detail below. All excerpts below are referenced as follows (group number: speaker number: line number).

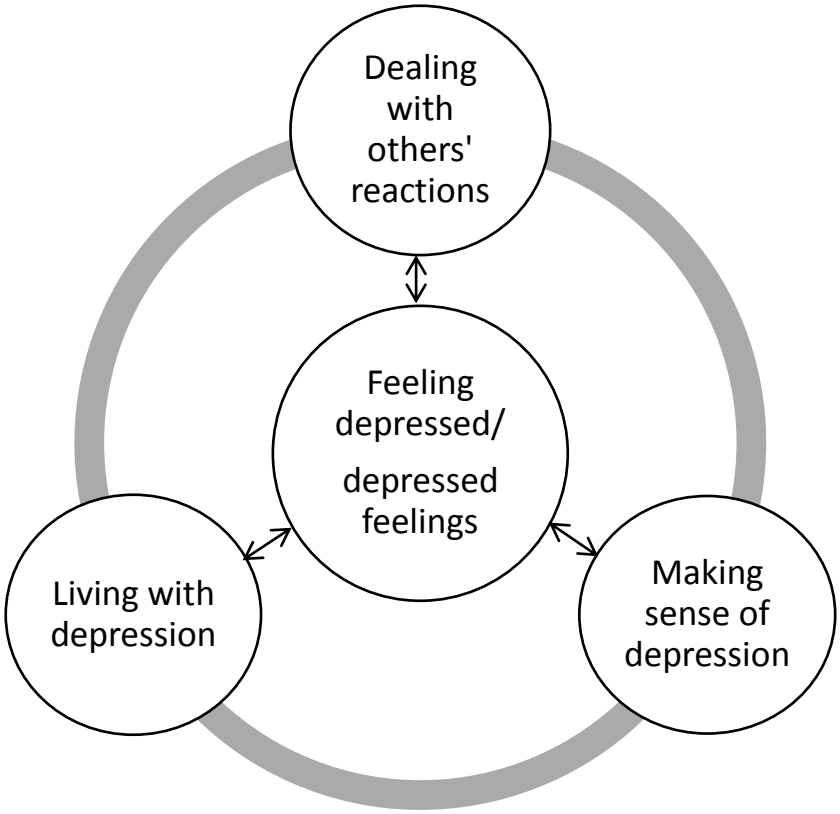

Figure 5-1 Main themes and their relationships

5.3.1 Theme 1: Feeling depressed/depressed feelings

Feeling depressed/depressed feelings emerged as the central, overarching theme and reflected the most immediate experience of depression with the least reflection and sense making. Feeling depressed was 'black', 'dark', like being in a 'deep hole' (2:S5:43). One participant likened it to having a black hole inside her:

> *…because I actually physically feel a black hole somewhere around here [points to lower chest] that's kind of like twisting and pulling on itself. That's usually around like around the height of it [points to chest] (2:S5:132).*
>
> *Because for me I feel like, if you feel like kind of like a black hole and you're like sort of everything that you say to yourself and do is kind of like it's just like sucking negative things down into it (2:S4:131).*
>
> *…it feels heavy and black (1:S4:203).*

Feeling alone and not wanting to be with others was another common experience and, in part, was linked to a fear of being judged or not properly understood:

> *I appreciate and understood a lot of what people were saying about sort of feeling uncomfortable talking to other people because you don't want to be a burden. You also don't want them to kind of go like, "Get over it. Oh it doesn't matter." Like to have your sort of pain or sadness ridiculed (2:S8:82).*

A key difficulty that emerged in Group 2 was not knowing the cause of the sadness which was, in part, linked to a societal and cultural 'pressure to be happy':

> *…even though I have no reason, supposedly no reason to be depressed you still kind of feel depressed and that sets the frustration. And also that kind of pressure to be happy. That's where depression often comes from for me. That sense of kind of needing to be [inaudible 00:04:25] and get on with things and enjoy what you have and make the most of the things and to succeed. So, but then still to feel depressed is a sense of kind of I guess failure or not being able to sort of get on in that but yeah… Depression for me is that ambiguity not knowing what the source. If I feel sad, I'm sad about a particular thing and it's quite clear how to process that or deal with that. The depression is that murky ambiguity as to where it's coming from and not knowing what to do about it (2:S3:18).*

Overall, depression was a deep, difficult, very painful and intense sadness combined with hopelessness, fear and sometimes anxiety. Feeling different and self-conscious while with others added more difficulties and challenges. Depression is not the same as being sad – where sadness will have an identifiable cause. Rather, for some, depression is intense sadness with no identifiable reason. It is heavy, murky, tangled, difficult to change, isolating, not easily understood by others.

5.3.2 Theme 2: Dealing with others' reactions

The reactions of others were a key aspect of all participants' depression and often added an additional burden. Other people often failed to properly understand the experience and wanted to either fix participants or for the participants to fix

themselves, to ‘suck it all up’. For many participants there was a fear of being a burden. Tied in with this is the issue of the risk/fear of others not taking the depression seriously, not considering it to be real but rather imagined or ‘indulgent’. There was a great deal of anticipation of others’ reactions which – in different ways - could add greatly to the pain experienced through the depression. For example, this participant described a battle between not wanting to burden others but wanting help from others too:

> *I find it also becomes like a bit of a battle between wanting to not burden others whether or not get [inaudible 00:06:27] but then also trying to sort of, I guess a cry for help a little bit and try to want people to sort of find out and ask you and sort of help. But even that you don’t so it becomes this kind of two-way thing where you know…you don’t know the source and you don’t know it yourself but you want, so you don’t want to like burden others but then you just don’t want to…you don’t want to cope alone (2:S4:23).*

There was also a link between (being with) others and feelings of difference and isolation. In particular others often seemed happier, able to get on with life and to enjoy a stable mood:

> *I still have this like jealousy of you know there’s people that it’s like always the same. That they’re always seemed to be in the same mood. They’re always happy. And I’m just like, “How is this? How do you do that?” Like I want to be that person. You know you don’t have to worry about like how are you going to feel when you wake up the next day. You know it’s not question of that. It’s just this kind of like you know neutral, happy, gliding through life thing. But I see in others that’s like that amaze me (2:S2:120).*

> *And I guess in a way when I feel really low I feel isolated in my low feeling. And I feel somewhat removed from everybody else and can’t really [group laughter]… can’t really reach out to anybody else. So it’s almost like this is how I feel. [Looking at image] I feel that for me, I’m the one without the umbrella. So it’s almost like everybody else is lovely and dry and happy and I’m the one who doesn’t have an umbrella and I’m getting all wet. And I guess my…when I’m feeling that desperate and low, I feel like nobody else would understand or nobody else would be there. And I sort of feel like everybody else’s life is perfectly okay and*

happy and cheery and then there's me who's alone in my sadness (1:S4:60).

5.3.3 Theme 3: Living with depression

For all participants, depression was something which came and went, often described in a cyclic way and having particular known and unknown triggers. Depression and feeling 'very low' can be 're-triggered' at any time.

And I was like now that I sort of starting to happen again I don't know if it's like just to realise that or maybe just the realisation that it becomes more of a long term kind of thing I have to deal with more than I thought I did. I think, yeah I think because I thought that it was gone completely. I can just sort of go back to doing the things that would sort of re-trigger it but yeah (2:S4:204).

All participants had different ways of coping with their depression, including ways to notice and anticipate the signs of falling back into depression, of some kind of relapse. These included giving in to the feelings, keeping busy, finding creative outlets, knowing the depression would pass, reminding oneself of the 'good things' and taking prescribed medication. Alcohol, smoking and recreational drug use were also identified as ways of coping but were not perceived in a positive way. Escape, retreat and getting away from others were key strategies in both groups:

If I really can't bear it then I have to go to sleep because it's almost like it's too overwhelming. It's too out of control. It's too difficult. And so then I just shut down. And I think I find it easier to cope with it if I can have a period away from it where I don't have to think about it. Then I feel like, "Okay, maybe I'll resolve it in a different way. Or find a different solution by hiding myself away from that thing (1:S4:126).

One participant found shopping lifted his sprits:

I like shopping [group laughter]. And sometimes I buy stuff just to feel happy again. But I think in a way, in a way it's also…it gives you a small change in your life. So you have something new. You just...new shoes for example. You're just like feeling excited about it and then wear it on the next day. And actually, they probably look like the shoes I bought two months ago [group laughter]. But it's just a small change in my life and it just distracts me maybe (1:S5:205).

Another interesting aspect raised only in Group 2 was an issue of not always wanting to leave the depression. This was also described as resisting and even resenting efforts by others to help and to make it better. Part of this resistance was linked with the fear that if participants could help themselves in some way then others would feel justified in thinking that the depression was imagined or less 'real'. However, there was also something deeper in the desire to stay 'in the hole', something *associated with the value of the depression, not wanting to 'undermine' the depression:*

> *Yeah, I wouldn't just say that talking about going for a walk or something and your resistance to that, a suggestion of helping you out of depression. I think for me I often have a resistance to those kind of suggestions so go for a walk or do this it will be nice or whatever. If you do suddenly feel better it's like it undermines the depression in the first place. So that's, it's like you do want to wallow in it because you're just saying to everyone this is real* (2:S3:209-210).
>
> *Yeah, but overall actually it's you resist it but it's not really something that you're choosing to do because you're consciously trying to like make sure that this has its value. It's just like just really hard to actually to do it [trying to overcome the depression] like it's such a big resistance (2:S4:219).*

Acknowledging responsibilities to others and maintaining a sense of purpose also helped for some participants:

> *I think having other people to worry about gives you...you know you don't have time to think about yourself and it also gives a sense of purpose, a sense meaning so if you're looking after a child then that...it's like you don't have to...it gives you that sense of purpose and sense of responsibility so you just don't have time to really dwell on yourself. But then again that introduces a new problem for neglecting yourself. But that has helped me to have a responsibility to someone else (2:S3:246).*

Some participants had taken anti-depressants and these were perceived as having both positive and negative effects. One participant had recently decided to avoid this option:

I went on them and I just recently come off. And it was like I just need...I just was so much more neutral but like I used to like cry if I heard a song that moved me or a painting or whatever it was and it was almost like I'd rather have to like deal with this lows and maybe that will teach something for myself or like turn, make me turn to things that I wouldn't have otherwise turned to but it's a natural thing. And I think I'd rather be who I am and be moved by things than be shut off to them and just kind of feel okay all the time (2:S2:168).

5.3.4 Theme 4: Making sense of depression

All participants framed their depression in some way, made sense of their experience in a wider context beyond themselves. In Group 1 there was a clear distinction between 'real' depression and intense sadness, feeling 'very low'. In Group 2 there was a distinction between ordinary sadness (which has an identifiable cause) and depression (where there is no obvious cause), although this was not the case for all participants. There was also reflection on what leads to or causes participants' depression and low mood, for example the following participant described his lack of motivation as a cue that he may be depressed:

What you said about motivation as well I think for me that's a really big thing. Because if I don't have, I think you have to be motivated in this level. I think if I don't have that motivation then I'm in a bad place. And I feel that on occasion where I just don't feel motivated to go into work or do anything or be bothered with anything and that's a real cue for me yeah (1:S3:146).

Finally, several existential issues emerged. There was reflection on a type of attitude or tendency towards depression which was shared by several participants in Group 2:

…so it comes down a lot of the time to a sort of a general outlook on existence as much as and some people have like a more optimistic and some people have more pessimistic attitude towards just like the very fact of one's existence (2:S4:238).

Another participant felt that too many choices contributed to his depression and that having his choices limited (externally) helped him cope:

> *It's like too many options for me made me dwell on which one I would choose. But if it's lack of options pulls you through and makes you kind of...it just shows you the way. It's like you don't have to, that is like I always felt that too much choice and lack of direction that's often what I consider depression for me. That having you know having to make it, the decision quickly or having to think about someone else it's just, there's no choice (2S3:251).*

The dualistic nature of sadness/depression and happiness was questioned by one participant in making sense of her depression:

> *...happiness isn't necessarily the flipside or the opposite. But I mean one of the things that certainly helped me was understanding that you have a range [inaudible 01:05:26]. You have to go through all of them. But sometimes I think, I felt depression and sadness at times when I've gone, "Mm. Actually, I'm not happy. Why am I not happy?" And I sort of like this pressure to be constantly happy and if you aren't constantly happy then you must be kind of sad or depressed or like there's never an in between or like normal (2:S8:226).*

5.4 Construction of Q-set

The data derived from these two focus groups provided a wealth of material which contributed towards the construction of the Q-set. While this preliminary aspect of the research formed only one element of the various sources of statements, these focus groups were particularly useful in indicating some of the main themes that needed to be included. The focus group research also usefully enabled reflection on the boundaries between the more immediate experience of depression and related processes of sense making, for example understandings of causes, triggers, predispositions, ways to cope and so on and how those boundaries related to this study and especially the development of the Q-set. Finally, the detailed accounts gleaned from this preliminary study enabled me to get a deeper and richer sense of what mattered to the participants along with the common and unique elements of their experiences which I took forward to the main Q-methodological study.

Chapter 6 Results

6.1 Introduction

In this chapter I present the results of the main Q-methodological study, explicating each of the factors that were obtained following the principal components factor analytical procedure described in Chapter 4 (section 4.9.5). Here each of the (orthogonal) factors represents a different experience of depression, where each experience is shared among at least two participants. Of particular interest at this point is the dispersed nature of the results given that eight distinguishable experiences have emerged. Thus, rather than the study revealing a small number of factors which explain a large proportion of the variance (as would be the case with a 2 or 3 factor solution), all 8 factors satisfied all 3 criteria for selection and interpretation, please see the section below (6.2) for a description of these. This shows that given an inclusive range of statements concerning the experience of depression, participants report a diverse array of experiences.

In the first part of this chapter I present the overall outcomes of the study (tables of the overall statistical results can be found in Appendix 5). I then provide an explication of each factor incorporating the relative placement of statements, distinguishing statements and participants' follow-up comments. The nine statements taken from the key diagnostic criteria for major depression in the DSM-5 are shown in bold throughout the chapter for ease of identification and the placement of these particular statements is also interpreted and discussed. I then conclude by providing a summary of the findings. All participants are referred to by their participant number. I go on to discuss the relevance of the results in more detail in Chapter 7.

6.2 Statistical results for all factors

There are three accepted criteria for the selection of interpretable factors (Brown 1980; Watts and Stenner, 2012). The first two are that an interpretable factor should have an eigenvalue of 1 or above and that at least two participants load significantly on the factor. All eight factors satisfied these criteria. A final criterion for selection is to determine whether there is a point in the data where the cumulative explained variance for each factor levels off. This is determined by making a graph of cumulative explained variance for each factor. As can be seen in Figure 6.1 below, this final method of selection indicates that all factors should be interpretable as there is no point after which a (roughly) flat line appears, which would show that one or some factors do not explain sufficient variance within the data. Instead, all factors appear to be interpretable, giving a clear indication that there are several different experiences of depression emerging in the study:

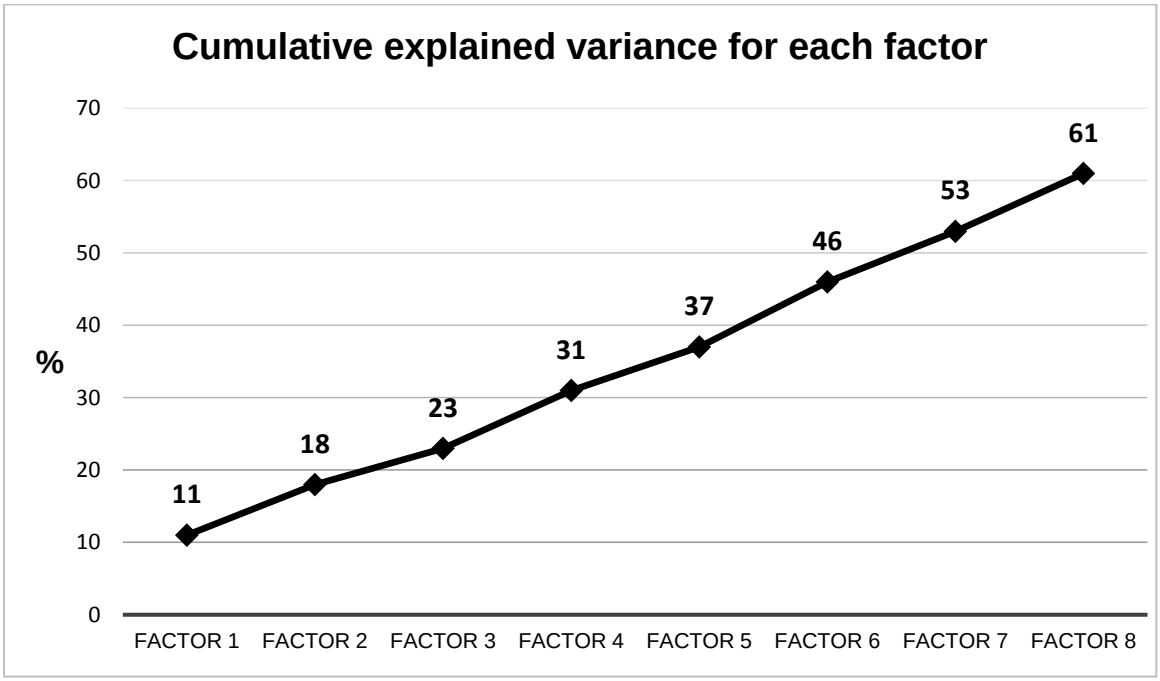

Figure 6-1 Graph of cumulative explained variance by factor

All defining Q-sorts for each factor were positively loaded, meaning that there were no mirror image significant loadings, please see Appendix 5 for the rotated factor matrices showing defining sorts.

Table 6-1 Factor Scores for Each Statement

No	Statement	1	2	3	4	5	6	7	8
1	I experience a deep feeling of being alone and cut off from other people	2	4	-2	5	4	5	0	1
2	Although on the outside I seem okay, on the inside I'm going through hell	1	2	5	-1	4	5	0	3
3	I feel as though others have no idea how truly awful the experience is	1	0	5	-1	3	4	3	-2
4	I experience all sorts of aches and pains around my body	1	3	2	-3	-5	-2	0	-1
5	I feel tense and anxious most of the time	0	2	5	3	2	2	0	2
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-1	-4	-1	0	-3	-3	4	1
7	**I notice that most of the time my bodily movements have slowed right down**	-2	-2	-2	-3	3	-2	0	-1
8	**I experience fatigue or loss of energy nearly every day**	4	0	-4	0	2	1	0	2
9	I have little or no interest in sex	1	2	3	-2	-1	-3	1	5
10	I intentionally injure my body, for example cutting or burning my skin	-5	-3	-5	-5	-5	2	-5	-5
11	**I feel sad and/or empty much or all of the day**	5	1	2	4	5	4	2	2
12	I find myself dwelling on the things that I've lost	2	1	0	3	5	-2	-3	4
13	**My interest and/or pleasure in almost all of my activities is very diminished**	3	2	4	2	1	1	-2	3
14	**Most of the time my ability to concentrate and make decisions is diminished**	2	0	3	2	1	3	-1	-1
15	I find myself becoming more aggressive	-3	0	-1	1	0	-3	2	2
16	I am sometimes totally devoid of feeling	3	-1	2	5	-1	0	1	0
17	I feel as though everything is hopeless	4	-3	1	0	1	3	-1	4
18	However bad it gets I know that I have to survive and get through it	0	3	3	-1	5	-1	5	3
19	**I experience recurrent thoughts of death and of taking my own life**	5	-5	-5	-2	-4	0	-5	-1
20	I find that sleep is my only escape	2	-1	-3	0	-4	2	1	-1
21	**I experience a decrease in my appetite nearly every day**	-1	-1	-5	0	-1	-4	-3	-5
22	**I find myself sleeping too much nearly every day**	0	0	-4	-4	-3	-1	-3	-1

23	**I feel worthless and/or excessively guilty nearly every day**	5	2	-4	4	-2	1	0	1
24	I feel as though other people think I'm just being selfish	-2	-1	3	-3	-1	1	3	-2
25	I get this internal voice which is negative and very critical of myself	4	-4	4	4	4	0	1	2
26	I know that I'm not helpless, I can get myself out of it	-1	4	2	-1	1	-4	4	0
27	No matter how hard I try I just can't take control of my thoughts and my feelings.	1	4	-2	1	-1	4	-2	1
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	-3	1	0	0	4	-2	3	4
29	I find myself taking many more risks than I would normally	-4	-2	-3	3	0	-4	-1	-3
30	Time seems to slow down for me	0	-2	-2	-2	2	-1	-1	0
31	I find it hard to imagine a different or better future	3	-5	2	1	1	0	-3	-1
32	I have alternating periods when I'm down and when I'm up	1	5	-1	4	1	-2	-1	1
33	I feel as though something, like a chemical, has been released in my brain.	-2	-1	3	-2	-4	0	-2	-2
34	My feelings could be best described as the 'blues'	-3	5	-1	1	-2	-3	5	-1
35	I know that it's the price I have to pay for creativity	-4	1	-3	-4	-2	0	-1	1
36	I am aware that it is a result of a physical illness	-2	-1	0	-5	-2	-5	-3	-3
37	I am aware that I need to get some sunshine	0	1	1	2	2	-3	4	0
38	Although it's difficult right now, I know it's part of the cycle of life	-1	3	0	-3	3	-4	2	5
39	I find myself struggling with the question 'how do you live this life?'	4	-3	1	4	0	2	1	2
40	I feel that I need answers to why this is happening to me	-3	-2	-1	-1	0	0	1	3
41	I find myself wondering 'what's the point of my life?	1	0	1	2	2	4	2	4
42	My life and the world seem meaningless	3	-5	0	1	0	3	-1	5
43	Rather than burden others, I try to fix my problems for myself	-1	4	2	-2	2	5	5	1
44	Professional help is the last thing I need	-4	-1	-1	-1	-5	-2	2	0
45	Anti-depressant medication really helps me	0	-4	-3	-3	-3	-5	-2	-4
46	I cling to the belief that there is a God who cares	-2	-2	3	-5	-3	-5	4	-5
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	0	2	0	-4	-1	-1	-2	-2

48	I feel unsafe in my house, at work, everywhere	-1	-2	-3	-4	0	1	-4	-4
49	I fear being judged if I tell others about it	0	0	1	1	-1	1	3	-4
50	I'm not able to trust my senses, memory or my judgment	-1	-3	0	-1	-4	-1	-4	-3
51	I feel ashamed of my depression	2	1	-2	-2	-2	3	2	-3
52	I worry about the effect that my depression will have on my family and close relationships	3	5	-1	1	0	2	3	-3
53	I avoid seeing other people because I know I'll make them feel bad too.	-2	1	-2	2	3	3	-2	-2
54	I feel guilty that I can't just pull myself together	2	3	4	0	3	0	0	-1
55	I feel more anxious because I don't know what's causing it	-4	3	1	3	0	-1	-4	2
56	I find it hard to distinguish what's real and what I've imagined	-3	-3	-4	-1	-3	-1	-4	-3
57	I find myself becoming secretive and paranoid	-5	-4	1	3	-2	2	1	-1
58	I experience bizarre thoughts and delusions	-5	0	0	1	1	1	-5	-4

The above table shows the different ways that participants sorted statements for each factor.

Table 6-2 Consensus statement for the study

No	Overall Consensus Statement	Q-sort	z-scores
56	I find it hard to distinguish what's real and what I've imagined	-1 to -4	-0.44 to -1.37

There was only one consensus statement that emerged from the study, that is only one statement showed significantly similar sorting across all factors. Thus, there is relative consensus across the factors (overall shared disagreement) about this statement. However, while this statement did not (significantly) distinguish factors, it still provided a useful element, when considered alongside other statements, in the overall explication of individual factors.

6.3 Explication of factors

For each factor, I present the factor Q-sort grid, followed by a table of biographical details for the associated participants, before giving a detailed description of the characteristics of each factor. The explication of each factor should be read in conjunction with Table 6.1 above and the results tables found in Appendix 5.

6.3.1 Factor 1: 'Clinical'/suicidal depression

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**
10	29	15	**7**	6	5	2	1	**13**	**8**	**11**
57	35	28	24	**21**	18	3	12	16	17	**19**
58	44	34	33	26	**22**	4	**14**	31	25	**23**
	55	40	36	38	30	9	20	42	39	
		56	46	43	37	27	51	52		
			53	48	45	32	54			
				50	47	41				
					49					

Figure 6-2 Factor Array for Factor 1

Participants exemplifying this factor were all female and self-identified their depression as either moderate or severe. Three participants were White/British, one was Brazilian. Three of the four participants had been diagnosed with depression and had taken prescribed anti-depressant medication, one participant was currently taking medication.

Table 6-3 Biographical details of participants who exemplify Factor 1

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed anti-depressant medication?*
14	Female	36	White/British	Yes	Moderate	Yes, in the past
22	Female	47	Brazil	Yes	Moderate	Yes, in the past
25	Female	29	White/British	Yes	Moderate	Yes, currently taking
44	Female	71	White/Welsh	No	Severe	No

Of all the factors, Factor 1 most closely maps on to the diagnostic criteria for major depression found in DSM-5. Three of the nine DSM statements (closely

resembling the key DSM-5 diagnostic criteria for major depression) were placed at 5 and one at 4.

Table 6-4 Highest scoring statements for Factor 1

Number	Statement	Grid
23	**I feel worthless and/or excessively guilty nearly every day**	5
11	**I feel sad and/or empty much or all of the day**	5
19	**I experience recurrent thoughts of death and of taking my own life**	5
8	**I experience fatigue or loss of energy nearly every day**	4
25	I get this internal voice which is negative and very critical of myself	4
17	I feel as though everything is hopeless	4
39	I find myself struggling with the question 'how do you live this life?'	4

Two other DSM statements were placed at 2 and 3:

13	**My interest and/or pleasure in almost all of my activities is very diminished**	3
14	**Most of the time my ability to concentrate and make decisions is diminished**	2

Factor 1 represents an experience of depression that is exemplified by feelings of sadness and emptiness **(11: 5)**, guilt and worthlessness **(23: 5)**, fatigue and loss of energy **(8: 5)**:

> *I am just overwhelmed with sadness and grief and anxiousness, nothing was able to distract me. (P44)*
>
> *I feel like I am a project of human being that has irredeemably failed and that all that can be done is to wait for this meaningless life to come to an end… (P22)*

Participants associated with this factor also experience (seemingly to a lesser degree) a diminished ability to concentrate and make decisions **(14: 2)** and a diminished interest in almost all of their activities **(13: 3)**. In addition, there are some

feelings of shame (51:2) and guilt at not being able to 'pull myself together' (54: 2). Participant 25 describes her lack of energy and difficulty in concentrating, she also describes her sense of weakness and embarrassment at being depressed:

> *I just feel depleted and it's unimaginable having energy or ever feeling better. I end up sleeping very badly and needing to nap in the afternoon. It's a struggle to concentrate and take part in things when I feel so tired and it makes everything seem hopeless... How can I be so pathetic to feel like this? It feels like a personal weakness and extremely embarrassing… (P25)*

The experience also involves feelings of hopelessness (17: 4) and a negative and critical inner voice (25: 4):

> *The pain of being depressed is overwhelmingly linked to negative thoughts and feelings about myself, life and the world… I get stuck into a stream of recurrent negative thinking. It is as if everything I am or have in life was wrong… (P22)*

There are also worries about the effect of the depression on family and close relationships (52: 3) and an experience of struggling with the question 'how do you live this life?' (39: 4).

An essential element of this factor is the strong presence of thoughts of death and suicide. Indeed, experiencing recurrent thoughts of death and suicide was the sole distinguishing statement for this factor and was placed at 5 **(19: 5)**:

> *On the worst days these [suicidal] thoughts constantly hammer through my head. I end up seeing everything in the world through a lens of looking for means of killing myself e.g. seeing pipes on the ceiling in my office as a place to hang from, rail lines and high buildings take on the significance of places to throw life away. These thoughts feel like a plague, they are logical thoughts arising and not something I want to do or have any intention of really doing. Last year I had a particularly rough time with this so I stayed in bed for three days for fear that if I got up and went out I wouldn't be able to control the impulse of harming myself… (P25)*

In contrast, self-harm, for example cutting or burning the skin was strongly rejected in this factor (10: -5) and participants made a clear distinction between self-harm and suicide:

> *Self-harming is not part of my episodes of depression. In fact, this is not something that has ever crossed my mind – whether when I'm depressed or in good mental and emotional state. As a consequence of my depressive thinking (feelings of helpless and hopeless, feelings that life and myself are not worthwhile), I come across suicidal thoughts – which I fight against and manage to get out of my mind. But I never consider as an alternative to submit myself to more pain (through self-harm). I just don't see it as an alternative or a possible solution. In fact, this is a behaviour that just doesn't make sense to me and I've never felt like doing it… (P22)*

> *The thought of wishing I could cut out the pain occurred a lot but it never occurred to me to physically harm myself in that way [as in statement 10]. It was either death, by suicide, or simply continue to suffer. (P44)*

Here intentional self-harm is understood as bringing more pain while struggling with suicidal thoughts was something that all three participants described as a major element of their depression.

Table 6-5 Lowest scoring statements for Factor 1

Number	Statement	Grid
44	Professional help is the last thing I need	-4
55	I feel more anxious because I don't know what's causing it	-4
35	I know that it's the price I have to pay for creativity	-4
29	I find myself taking many more risks than I would normally	-4
58	I experience bizarre thoughts and delusions	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5
57	I find myself becoming secretive and paranoid	-5

In this factor there is a very strong rejection of what might be termed 'psychotic' experience, for example being 'secretive and paranoid' (57: -5), experiencing 'bizarre thoughts and delusions' (58: -5) and, to a lesser degree, distinguishing between what is real and what is imagined (56: -3):

I don't think I have this kind of feelings or behaviour [statement 57]… I don't get paranoid or secretive because I just isolate myself from the world. (P22)

I don't think suicidal thoughts are bizarre [statement 58]. I don't believe I was ever deluded. My judgment may have been a little skewed and my cognitive abilities a little diminished but I was always intensely aware of what was going on with me and around me. (P44)

There is also a rejection of the idea that this experience can be seen as the price to pay for creativity (35: -4) or understood as the 'blues' (34: -3), in contrast Participant 22 describes her sense of her depression as a disease:

There is somewhere the awareness… that it is part of a disease and a temporary state, that I need to fight against what is placing me in this position (P22)

In addition, there is a strong rejection of the idea that professional intervention will not help (44: -4):

I know full well from experience that professional help, medication and other treatments really do help. (P25)

There is also a rejection concerning increased risk taking (29: -4) and becoming more aggressive (15: -3), exemplified by participant 44:

No [disagreeing with statement 15], because no matter how bad I feel I would never bring it out on someone who didn't deserve it. (P44)

In summary, Factor 1 appears to most closely resemble 'clinical' depression in that six of the nine DSM statements were placed in the 'most like me' part of the scale. Three of these statements were placed at 5, and one at 4, and this agreement with so many of the DSM statements is unique to this factor. Recurring thoughts of death and suicide are a key feature of this experience and this is reflected through the relevant statement (19) emerging as the only distinguishing statement for this factor. This means that participants loading on Factor 1 sorted this statement significantly differently compared to all other factors. There was a high level of

severity of depression for participants exemplifying this factor and all but one participant had been diagnosed with depression, giving some further support for the 'clinical' nature of this factor. Here feelings of sadness, fatigue, guilt, shame, hopelessness and worthlessness are combined with diminished pleasure and concentration, fears about the effect of the depression on family and close relationships and a struggle with the question 'how do you live this life?'. There is a strong rejection of 'psychotic' experience and the idea that this experience of depression can be understood as the 'blues'. There is a generally positive view of professional help and a clear distinction between thoughts of suicide and intentional self-harm, such as cutting or burning the skin.

6.3.2 Factor 2: The 'blues'/overcoming loss and bereavement

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**
19	6	10	**7**	16	3	**11**	2	4	1	32
31	25	17	29	20	**8**	12	5	18	26	43
42	45	39	30	**21**	**14**	28	9	38	27	52
	57	50	40	24	15	35	**13**	54	43	
		56	46	33	**22**	37	**23**	55		
			48	36	41	51	47			
				44	49	53				
					58					

Figure 6-3 Factor Array for Factor 2

Three participants loaded significantly on Factor 2, one male and two females, all White/British. Two had been diagnosed with depression and one had taken antidepressants in the past. Participants described their depression as either mild or moderate. All three participants associated with this factor were middle aged or older, including one participant over 80.

Table 6-6 Biographical details of participants who exemplify Factor 2

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
16	Female	44	White/British	Yes	Moderate	Yes, in the past
34	Male	67	White/British	Yes	Mild	No
38	Female	83	White/British	No	Mild	No

Factor 2 represents an experience of depression that is very strongly identified as the 'blues' (34: 5) which here appears to contrast with the more 'conventional' (clinical) experience conveyed through Factor 1. Given that all but one of the DSM statements were placed within the central grid values (-2 to 2), these diagnostic criteria appear to have far less relevance for those participants associated with this experience.

Table 6-7 Highest scoring statements for Factor 2

Number	Statement	Grid
34	My feelings could be best described as the 'blues'	5
32	I have alternating periods when I'm down and when I'm up	5
52	I worry about the effect that my depression will have on my family and close relationships	5
43	Rather than burden others, I try to fix my problems for myself	4
1	I experience a deep feeling of being alone and cut off from other people	4
26	I know that I'm not helpless, I can get myself out of it	4
27	No matter how hard I try I just can't take control of my thoughts and my feelings	4

Here there is a strong sense of feeling cut off and alone along with an awareness and concern with others noticing the mood:

My mother would say 'I feel as though I stick out like a sore thumb'. (P38)

What appears to, in part, identify this experience as the ‘blues’ is an emphasis on knowing the reasons or causes of the depression along with a sense that the symptoms may reflect something other than depression:

> *My depression, if it is depression, is never very severe and always can be rationally related to events that have occurred to do with work or personal life. It may be more a symptom of stress as much as depression (P34)*

This aspect of awareness is also reflected in an agreement with the following statement (which was placed at -4 in Factor 1), here it seems that not knowing the cause of the depression may be more anxiety provoking:

55	I feel more anxious because I don't know what's causing it	3

There is also a key concern with the effects of the depression on others (52: 5), while at the same time there is a strong sense of self-reliance and the importance of self-help:

43	Rather than burden others, I try to fix my problems for myself	4
26	I know that I'm not helpless, I can get myself out of it	4
18	However bad it gets I know that I have to survive and get through it	3

For Participant 34 this self-help is linked to the notion of dealing with the source of the depression rather than the symptoms:

> *Although I have been offered anti-depressants I have never taken them as I don’t believe they would help as my depression, if that’s what it is, has a rational basis and therefore needs dealing with at source so to speak rather than covering up the symptoms. (P34)*

Interestingly, this emphasis on self-help is coupled with an experience of not being able to control one’s thoughts and feelings:

27	No matter how hard I try I just can't take control of my thoughts and my feelings.	4

Tied up with this form of the 'blues' is an experience of alternating moods, of highs and lows (32: 5), however these moods are presented as part and parcel of the depression (and perhaps of life) rather than as something separate or more 'clinical':

> *I try to even out my emotions to avoid the roller coaster but there are always highs and lows (P16)*

In addition to the importance of a strong sense of awareness concerning what the depression is about, participants associated with this factor describe loss and bereavement as a key cause, where depression is a rational response:

> *The times I feel depressed are when I can't share a feeling with somebody. Losing a partner means losing a whole piece of myself, others can't know how it feels. (P38)*

> *My sadness, if depression, is usually related to the loss of people, particularly family members. But this is I believe a quite rational response to the loss of someone as part of a healthy grieving (P34)*

There is a clear reluctance here to use the term depression to convey these emotions; for these participants it does not seem to fit with their experience. For this form of the 'blues', most of the time there is a clear (external) reason for the sadness which appears more a natural part of life rather than something 'clinical'. Indeed, there is also agreement with the notion that the depression will pass, which in turn confirms a sense that depression is part of a natural cycle:

38	Although it's difficult right now, I know it's part of the cycle of life.	3

Table 6-8 Lowest scoring statements for Factor 2

Number	Statement	Grid
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-4
25	I get this internal voice which is negative and very critical of myself	-4
45	Anti-depressant medication really helps me	-4
57	I find myself becoming secretive and paranoid	-4
19	**I experience recurrent thoughts of death and of taking my own life**	-5
42	My life and the world seem meaningless	-5
31	I find it hard to imagine a different or better future	-5

Only one DSM statement has a noteworthy placement in this factor **(19: -5)** and this denotes a very strong rejection of thoughts of death and suicide. Furthermore, there is strong rejection of several of the aspects associated with more 'severe' depression (exemplified in Factor 1); meaninglessness (42: -5), not being able to imagine a better future (31: -5), hopelessness, (17: -3), negative and self-critical thoughts (25: -4), struggling with the question 'how do you live this life?' (39: -3). Also there is a rejection of the more 'psychotic' aspects of depression (57: -4, 56: -3), and not being able to trust one's senses, memory or judgement (50: -3). Indeed, all five of the distinguishing statements for this factor are rejections (-3 to -5) of these more 'severe' aspects of depression. In addition, and concomitant with the emphasis on self-help and the depression having a clear cause in life events, medication is not seen as helpful for this type of depression (45: -4).

In summary, Factor 2 represents an experience of depression best described as the 'blues' (which appears to be reflected in participants' lower self-identified severity), where a strong sense/awareness that the cause of the mood is external, related to life events, especially loss and bereavement, is central. There is a very strong rejection of thoughts of death and suicide as figuring at all in this experience. Here the role of self-reliance and self-help are central, those who experience this

form of depression have a strong sense that they will be able to survive and get through it. There is also a strong feeling of being cut off from others, an alternation of periods of feeling up and down, along with concern for the effect that this depression may have on family and close relationships. Of interest here is that all but one **(19: -5)** of the DSM statements were distributed through the lower values of the grid, suggesting these statements do not have much salience for this factor. Finally, the distinguishing statements indicate an important rejection of some of the more 'severe', and to some extent 'clinical', aspects of depression, for example hopelessness, meaninglessness, critical self-thoughts and not being able to imagine a better future.

6.3.3 Factor 3: Anxious/'anti-clinical' depression

Least like me when depressed								Most like me when depressed		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
10	**8**	20	1	6	12	17	4	**14**	9	2
19	**22**	29	**7**	15	28	37	**11**	18	**13**	3
21	**23**	35	27	32	36	39	16	24	25	5
	56	45	30	34	38	41	26	33	54	
		48	51	40	42	49	31	46		
			53	44	47	55	43			
				52	50	57				
					58					

Figure 6-4 Factor Array for Factor 3

Two participants loaded significantly on Factor 3, both were males, one was White/British and one was British/Asian. Both participants self-identified their depression as mild and neither had ever been diagnosed with depression nor been prescribed medication for it. Both participants were middle aged.

Table 6-9 Biographical details of participants who exemplify Factor 3

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
18	Male	46	White/British	No	Mild	No
32	Male	52	British/Asian	No	Mild	No

Factor 3 represents an experience of depression in which tension and anxiety are central aspects (5: 5), indeed statement 5 was given the highest score here of all the factors.

Table 6-10 Highest scoring statements for Factor 3

Number	**Statement**	**Grid**
5	I feel tense and anxious most of the time	5
2	Although on the outside I seem OK, on the inside I'm going through hell	5
3	I feel as though others have no idea how truly awful the experience is	5
13	**My interest and/or pleasure in almost all of my activities is very diminished**	4
25	I get this internal voice which is negative and very critical of myself	4
54	I feel guilty that I can't just pull myself together	4
9	I have little or no interest in sex	4

At the same time there is a strong sense of covering or concealing the depression and anxiety, where one possible consequence of this covering appears to be a feeling that others simply don’t understand the magnitude of the depression:

> 2 Although on the outside I seem OK, on the inside I'm going through hell 5
> 3 I feel as though others have no idea how truly awful the experience is 5

Interestingly, this masking/covering is not necessarily the same experience as isolation or feeling cut off:

1	I experience a deep feeling of being alone and cut off from other people	-2

Instead here there seems to be a covering of the experience which then links to others not knowing about the extent of the depression - where the experience is a private one, an experience that stays 'inside'. Furthermore, there is a sense of independent self-reliance here too:

> *It can be a private battle of which I'm not seeking sympathy (P18)*

Other key features of this experience include a loss of interest and pleasure which includes a loss of interest in sex, a critical and negative internal voice and a diminished ability to concentrate and make decisions:

13	**My interest and/or pleasure in almost all of my activities is very diminished**	4
25	I get this internal voice which is negative and very critical of myself	4
9	I have little or no interest in sex	4
14	**Most of the time my ability to concentrate and make decisions is diminished**	3

Statements **13** and **14** (along with statement **11**) were the only DSM statements that were agreed with in this factor. For one participant associated with this factor, the experience of loss of pleasure and energy are pronounced:

> *I do experience a lowering of my energies and my sense of joy. This has been a part of me, I think, from a young age. I have always struggled to connect to the feelings of joy and pleasure. So when I am feeling depressed, this state becomes particularly prominent… thoughts of sex or physical pleasure become terribly subdued. Perhaps it's an age-related phenomenon as well (I'm in my 50's)! (P32)*

There is also a role of faith in God, here this appears to offer some consolation to participants associated with this factor:

46 I cling to the belief that there is a God who cares 3

There is also a link here between faith and spirituality and a focus on the inner life:

> *My understanding about life is that the purpose of this life is to get to know the nature of the self, and its relationship to the soul. The various afflictions we experience in life are a reflection of this disconnection between the self and the soul. When the self is aligned to the soul, then it tends to produce greater harmony. So, in a sense, when I am experiencing periods of depression, low mood, hopelessness etc., then I cling to the knowledge that the answer, the solution, lies within. (P32)*

Feelings of sadness and emptiness **(11: 2)** are a part of this experience but do not appear central, and this is in contrast to several other factors (1, 4, 5 and 6).

Table 6-11 Lowest scoring statements for Factor 3

Number	Statement	Grid
8	**I experience fatigue or loss of energy nearly every day**	-4
56	I find it hard to distinguish what's real and what I've imagined	-4
23	**I feel worthless and/or excessively guilty nearly every day**	-4
22	**I find myself sleeping too much nearly every day**	-4
19	**I experience recurrent thoughts of death and of taking my own life**	-5
21	**I experience a decrease in my appetite nearly every day**	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5

One key element of this factor is a very strong rejection of intentionally injuring the body (10: -5):

> *I have never engaged in physically self-injurious behaviour: it's too painful! It's not something that would help me. (P32)*

> *I have never done these things (P18)*

Appearing to be related to this is a very strong rejection (matching Factors 2 and 7 but contrasting with Factor 1) of thoughts of death and suicide **(19: -5)**:

I haven't experienced major suicidal thoughts, partly related to my beliefs about God. I have occasionally had thoughts about what it would be like to cease to exist, the possible effects of general anaesthesia, etc. However, I haven't engaged in any planning of death etc. (P32)

Indeed, an important defining feature of this factor is the level of rejection of the DSM statements. There was overall disagreement with 6 of the 9 DSM statements and five of these are placed at either -5 or -4. Thus, there is, as mentioned, a strong rejection of thoughts of death and suicide **(19: -5)**, of a decrease it appetite **(21: -5)**, of sleeping too much **(22: -4)**, of feelings of worthlessness and excessive guilt **(23: -4)**, of fatigue or loss of energy **(8: -4)**, and to a lesser extent, of slowed bodily movements **(7: -2)**. This placement of so many DSM statements in the negative area indicates that this factor is substantively different from the conventional 'clinical' notion of depression, not easily fitting into the pattern recognised by standard clinical diagnostics. Furthermore, the two distinguishing statements for this factor are both rejections of DSM statements **(8: -4; 23: -4)**.

In addition to a rejection of many of the DSM statements, there is also strong rejection of one of the more 'psychotic' aspects of depression:

56	I find it hard to distinguish what's real and what I've imagined	-4

I am very cognisant of my environment [responding to statement 56] (P18)

And a rejection of generalised feelings of being unsafe:

48	I feel unsafe in my house, at work, everywhere	-3

To summarise, this factor represents an experience of depression with anxiety and strong rejection of much of the key DSM diagnostic criteria at its core. There is also an emphasis on the diminishing of interest and pleasure, including interest in

sex and a diminished ability to concentrate and make decisions. A negative, critical internal voice and a feeling of guilt at not being able to 'pull myself together' are also key to this experience. There is also a masking or covering of the depression combined with a feeling that others are not aware of just how difficult the feelings are. This is also reflected in a view of depression as a 'private battle'. At the same time there is a focus here on inner (for some, spiritual) experience and the positive impact of a belief in a God who cares. The strong rejection of many of the DSM statements signals that this experience is substantively different to the accepted 'clinical' type of depression. This includes a very strong rejection of thoughts of death and suicide along with rejection of loss of energy, feelings of guilt and worthlessness, reduced appetite and excess sleeping as figuring in this experience. This is also accompanied by strong rejection of some of the 'psychotic' aspects of depression, for example not being able to distinguish between what is real and what is imagined, and intentional self-harm.

6.3.4 Factor 4: Emotionally devoid/isolated depression

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**
10	**22**	4	9	2	6	15	**13**	5	**11**	1
36	35	**7**	**19**	3	**8**	27	**14**	12	25	16
46	47	24	30	18	17	31	31	29	32	**23**
	48	38	33	19	20	34	37	55	39	
		45	43	26	**21**	49	41	57		
			51	40	28	52	53			
				44	50	58				
					54					

Figure 6-5 Factor Array for Factor 4

Two participants loaded significantly on this factor, one female and one male, ages 29 and 45, both White/British and both self-identifying their depression as moderate. Both participants had been diagnosed with depression at some time and one had taken prescribed medication in the past.

Table 6-12 Biographical details of participants who exemplify Factor 4

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
11	Female	29	White/British	Yes	Moderate	No
19	Male	45	White/British	Yes	Moderate	Yes, in the past

Factor 4 represents an experience of depression with very strong feelings of being alone and cut off (1: 5), feelings of worthlessness and guilt **(23: 5)** and a strong sense of sometimes being devoid of all feeling (16: 5), at its core. There is also a questioning of 'life' and how to live it (39: 4; 41: 2), alternating periods of being up and then down (32: 4), a negative and critical internal voice (25: 4) and some feelings of anxiety (5: 3; 55: 3).

Table 6-13 Highest scoring statements for Factor 4

Number	**Statement**	**Grid**
16	I am sometimes totally devoid of feeling	5
1	I experience a deep feeling of being alone and cut off from other people	5
23	**I feel worthless and/or excessively guilty nearly every day**	5
32	I have alternating periods when I'm down and when I'm up	4
39	I find myself struggling with the question 'how do you live this life?'	4
11	**I feel sad and/or empty much or all of the day**	4
25	I get this internal voice which is negative and very critical of myself	4

The experience of being devoid of all feeling is key to understanding this factor and the associated statement is distinguishing (16: 5), having been given a far higher score here than for any other factor. The two participants associated with this factor both describe a bleak feeling of emptiness, experiences of being numb, of fragmentation and disorientation, of just sitting and staring for long periods:

> *I find myself just sitting staring into space, not thinking, not noticing time pass. I don't feel anything except empty. Also I've found that I can*

happily talk to anyone, be 'friends' with anyone, but it's not a genuine friendship. It's like it's an act, I don't care. I've also separated sex from all feeling. I sleep with people I have no interest in and I can't tell if I actually like someone or if I'm just filling a gap in my life. I do it and then hate myself after. (P11)

I always thought depression was feeling down, at worst it encapsulated feelings of being inconsolable with sadness or grief or despair. I came to realise what depression was when my sister came to see me one day and I had been sitting in my own shit in the dark in silence on the sofa for three days unable to move. I had been staring at the remote control only feet away from me on the coffee table wishing there was something on the TV. I then knew what depression was: fragmentation, disorientation, a total eradication of who I was or what I wanted or who I loved or what I once hoped I could be. (P19)

However, this experience of disorientation and fragmentation, of feeling numb and empty, of sitting and staring for long periods, is not the same as sleeping too much:

22 **I find myself sleeping too much nearly every day** -4

Another crucial element of this factor is the presence of profound feelings of isolation and difference:

I can be surrounded by people, even people I know, and feel totally alone. I feel like I'm the only one that likes the things I like. I feel different from 90% of the population and I'm rarely around the other 10%... I feel like everyone is getting on with their own lives and have forgotten about me. Their other friends are their priority. (P11)

There is also an increase in risk-taking associated with this factor and the relevant statement (29) is the second distinguishing statement:

29 I find myself taking many more risks than I would normally 3

I swung [following a period of sitting, staring, being unable to move] into something quite different – still cut off and fragmented but drug ridden and promiscuous. I fucked everything I could, ever more cold and self-hating, incapable of stopping… not even the despair and anger on their faces [of friends and family] could stop me in the pursuit of crystal methamphetamine and fucking. (P19)

There is also some experience of dwelling on the things that have been lost (12: 3):

> *I constantly think how I've wasted the last 7 years of my life with one person, how I made a career decision because of them that wasn't what I wanted, and also how I lost someone I would have given up everything for. (P11)*

Table 6-14 Lowest scoring statements for Factor 4

Number	Statement	Grid
48	I feel unsafe in my house, at work, everywhere	-4
22	**I find myself sleeping too much nearly every day**	-4
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	-4
36	I am aware that it is a result of a physical illness	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5
46	I cling to the belief that there is a God who cares	-5

Factor 4 is also characterised by a rejection of the helpfulness of anti-depressant medication (45: -3), a general feeling of being unsafe (48: -4) and depression as a price to pay for creativity (35: -4). There is very strong rejection of the notion that depression is a result of physical illness (36: -5) and this aspect of the experience appears to be complex, as is evidenced by comments from Participant 19:

> *If I thought it were an illness – I would either feel that it was separate from me and therefore I should not feel the shame – but at the same time such a radical separation from myself allows me, when I am in the throes of self-destroy mode, to abnegate responsibility for my actions 'because I am ill'. (P19)*

For this participant, the notion of depression as the result of an illness suggests the possibility of a sense of separation between the 'condition' and the self. On the one hand an understanding of depression as resulting from an illness may remove the feelings of shame, on the other hand a separation between the depression and one's

sense of self may enable a denial of personal responsibility, which in this case was linked to a struggle with addiction.

There is also strong disagreement in this factor with the comfort associated with a belief in God (46: -5):

Please spare me the tedium of God when I am depressed. (P19)

I have no belief in God (P11)

And a strong rejection of intentional self-harm as an element of the experience (10: -5):

Never done this – or thought about it. (P19)

The DSM statements are fairly well spread throughout this factor indicating that the more conventional diagnostic criteria do not adequately capture this form of depression. There was strong disagreement with the criterion of sleeping too much every day **(22: -4)** and disagreement with slowed bodily movements **(7: -3)** and thoughts of death and suicide **(19: -2)**. This does not mean that suicidal thoughts are absent from this experience of depression but rather that they are not necessarily central; in other words thoughts of death and suicide may form a part of the experience but are not necessarily at its core. Furthermore, suicidal thoughts may be linked with other aspects of this experience of depression for example asking oneself the question 'what is the point of my life?' (41: 2):

> *I sank into withdrawn suicidal ideation, as I audited ways to kill myself and took tentative steps to perfect my art. Suicidal ideation – the overriding sense that I can't face another 45 years like the 45 years I've already had [responding to statement 41] (P19).*

In summary, this form of depression is characterised by an experience of sometimes being devoid of all feeling, by profound and bleak feelings of isolation and difference, guilt, worthlessness, sadness and emptiness. Sitting and staring for hours

or days, not noticing time pass, is described by both participants associated with this factor. Increased risk-taking and dwelling on the things and people that have been lost are also an integral part of this form of depression. The DSM statements are fairly evenly spread throughout this factor and there is a very strong rejection of depression as a physical illness, of gaining comfort in the belief in God and of intentional self-harm. The strong rejection of an understanding of depression as a physical illness is here suggestive of a complex understanding of the relation between the physical realm (illness) and the mental realm (self), where these may be experienced as separate from one another and this, in turn, may impact on feelings of shame and the sense of responsibility for one's actions. Here both participants self-identify their depression as moderate and both describe how this form of depression can be a deeply stultifying, numbing, isolating and disorienting experience.

6.3.5 Factor 5: Sadness and loss/surviving depression

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**
4	**19**	6	**23**	9	15	**13**	5	3	1	**11**
10	20	**22**	34	16	29	**14**	**8**	**7**	2	12
44	33	45	35	**21**	39	17	30	38	25	18
	50	46	36	24	40	26	37	53	28	
		56	51	27	42	31	41	54		
			57	47	48	32	43			
				49	52	58				
					55					

Figure 6-6 Factor Array for Factor 5

Three participants loaded significantly on Factor 5, one male and two females, two White/British and one White/German. All participants were either in their 30's or 40's. Self-identified severity of depression was moderate to severe, one participant had been diagnosed with depression and all three had never taken prescribed antidepressant medication.

Table 6-15 Biographical details of participants who exemplify Factor 5

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
26	Female	45	White/British	Yes	Moderate	No
29	Male	36	White/German	No	Severe	No
42	Female	42	British/Asian	No	Severe	No

Factor 5 represents an experience of depression that centres around loss (12: 5), survival (18: 5) and feelings of sadness and emptiness **(11: 5)**.

Table 6-16 Highest scoring statements for Factor 5

Number	**Statement**	**Grid**
12	I find myself dwelling on the things that I've lost	5
18	However bad it gets I know that I have to survive and get through it	5
11	**I feel sad and/or empty much or all of the day**	5
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	4
25	I get this internal voice which is negative and very critical of myself	4
1	I experience a deep feeling of being alone and cut off from other people	4
2	Although on the outside I seem OK, on the inside I'm going through hell	4

Participants associated with this factor describe loss as a central aspect of their depressed mood:

> *Depression occurs to me most often when someone or something (event/experience/possibility) has vanished/gone/disappeared/ended. It's a reminder of temporality and finitude in life. (P29)*

> *Important losses are hard to get over. I usually linger in melancholia for a while, and can't deal with the subject for a few months. (P26)*

There is another loss reported in this factor, a loss of self-control (28: 4) with respect to drinking and smoking:

Yes, that happens quite consistently, smoking and drinking seem to be my allies and I have little or no control on how much I smoke or drink. The only thing I do is drink and drink myself to sleep but at home. (P42)

This loss of self-control however, does not necessarily equate with increased risk-taking, although the placement at zero may indicate some ambivalence here:

29 I find myself taking many more risks than I would normally 0

There is a strong agreement that sadness and emptiness are a major aspect of this experience, where the relevant statement **(11: 5)** is given the joint highest score among all factors (joint with Factor 1). One participant describes these feelings of emptiness and sadness as linked with an inability to comprehend any meaning and purpose in life:

I really don't understand the purpose and meaning of life when I am in this space, so there's emptiness and sadness, sadness because I have a family but even their existence does not matter – nothing makes me happy. (P42)

There is also a deep feeling of being cut off from others (1: 4), as exemplified by Participant 26:

Because it's hard to tell friends about it, even friends whom I know would understand it. I have a tendency to think that I can manage, but then I feel lonely. It's as if I knew people would cut me off, although they actually don't. (P26)

Also key to this factor is a very strong sense of having to survive the experience (18: 5), indeed here this statement is also scored joint highest among all the factors (joint with Factor 7). One participant describes how she knows she will get through the depression:

There are moments, many of them, in the day when I know I have to and will get through it. As I am a therapist in training, I believe in my therapeutic work and know I will get through it. (P42)

An internal self-critical voice (25: 4), a disparity between what is shown to others and what is happening inside (2: 4) combined with a sense that others don't know how bad the feelings really are (3: 3) are also important elements of this experience of depression.

Table 6-17 Lowest scoring statements for Factor 5

Number	Statement	Grid
33	I feel as though something, like a chemical, has been released in my brain	-4
19	**I experience recurrent thoughts of death and of taking my own life**	-4
20	I find that sleep is my only escape	-4
50	I'm not able to trust my senses, memory or judgement	-4
4	I experience all sorts of aches and pains around my body	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5
44	Professional help is the last thing I need	-5

Another key element of this experience is a belief in the value of professional help and this statement is one of two distinguishing statements for Factor 5 (44: -5). Interestingly, all three participants associated with this factor are either therapists or therapists in training and this belief in the value of professional help comes with some questioning of the utility of medical and drugs based approaches:

45 Anti-depressant medication really helps me -3

I believe in therapy and meditation, but not medical intervention! No antidepressants for me. (P42)

Aside from being a therapist, I have been in therapy for the last 15 years, so I guess I do believe in professional help [rather than drugs]. (P26)

Seemingly related to this rejection of medical intervention is a strong rejection here of an organic, physiological basis for depression:

33 I feel as though something, like a chemical, has been released in my brain -4

Further strong rejection of an association with bodily aches and pains (4: -5) appears to be linked to this rejection of a change in brain chemistry, however there is not a wholesale rejection of a bodily basis and the utility of medicine and drug therapy:

> *I don't agree with it 100% [depression as a physical illness]. Not every depression is caused by chemical unbalance. Eventual, mild depression is part of life. Therapy is better than medication in many cases. Would only agree to use medication in extreme situations. (P26)*

As with six other factors (1, 3, 4, 5, 7 and 8) there is a strong rejection of intentional self-harm (10: -5) as a part of this experience of depression:

> *Certainly not. A horrible scenario but never experienced it. (P29)*
>
> *I could never see myself doing that (P26)*

There is also a strong rejection of sleep as an escape (20: -4), thoughts of death and suicide **(19: -4)** and not being able to trust one's senses, memory or judgment (50: -4):

> *I feel I have a very strong and stable connection to my perception and Being. Although losing control over this would be very scary and horrifying, it has never happened to me as yet. (P29)*

In this factor, the DSM statements are spread fairly consistently across the factor, where the strongest agreement is with statement **11 (5)**, referring to sadness and emptiness and the strongest disagreement is with statement **19 (-4)**, referring to thoughts of death and suicide. Interestingly, the second distinguishing statement for this factor is a DSM statement:

7 **I notice that most of the time my bodily movements have slowed right down** 3

Because I want to but can't exercise, I feel lazy and sleepy. (P26)

This suggests that a slowing down of bodily movements, although not central to this particular experience of depression may distinguish it, to some extent, from some of the other experiences uncovered in this study.

In summary, Factor 5 represents an experience of depression with feelings of sadness and emptiness, a dwelling on loss and a strong sense of survival at its core. There are also feelings of being cut off from others, a critical and negative inner voice and a loss of normal self-control, especially with drinking and smoking. All three participants associated with this factor were either therapists or therapists in training and this is reflected in a strong belief in the value of professional help, in particular psychotherapy and meditation. There is a strong rejection of intentional self-harm as an element of this depression, of thoughts of death and suicide, of chemical, bodily causes and medical and drug based treatments. The DSM statements are quite consistently spread throughout the factor, indicating a lack of fit with the received diagnostic criteria, with five of the nine statements being placed in the ‘most like me’ columns, but only two of these statements eliciting a stronger agreement, feeling sad and/or empty and a slowing of bodily movements. This experience of depression is self-identified by associated participants as more severe and overall is characterised by a dwelling on or struggling with loss, feelings of sadness and emptiness and feelings of being isolated and cut off from others, along with the need to survive the depression.

6.3.6 Factor 6: Alienated/helpless depression

Least like me when depressed — Most like me when depressed

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
36	**21**	6	4	18	16	**8**	5	**14**	3	1
45	26	9	**7**	**22**	**19**	**13**	10	17	**11**	2
46	29	15	12	30	25	**23**	20	42	27	43
	38	34	28	47	31	24	39	51	41	
		37	32	50	33	48	52	53		
			44	55	35	49	57			
				56	40	58				
					54					

Figure 6-7 Factor Array for Factor 6

Three participants loaded significantly on this factor, all female with ages ranging from 19-49. Two participants were White/British and one Black/British, all have been diagnosed with depression and two have taken anti-depressants in the past. All three participants self-identified their depression as moderate.

Table 6-18 Biographical details of participants who exemplify Factor 6

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
4	Female	49	White/British	Yes	Moderate	Yes, in the past
12	Female	35	Black/British	Yes	Moderate	No
30	Female	19	White/British	Yes	Moderate	Yes, in the past

Factor 6 represents an experience of depression which has feelings of isolation, being alone and cut off from others (1: 5), avoidance of burdening others (43: 5) and a holding in or covering of the depressed feelings (2: 5) at its core.

Table 6-19 Highest scoring statements for Factor 6

Number	Statement	Grid
2	Although on the outside I seem OK, on the inside I'm going through hell	5
1	I experience a deep feeling of being alone and cut off from other people	5
43	Rather than burden others, I try to fix my problems for myself	5
27	No matter how hard I try I just can't take control of my thoughts and my feelings	4
41	I find myself wondering 'what's the point of my life?'	4

11	**I feel sad and/or empty much or all of the day**	4
3	I feel as though others have no idea how truly awful the experience is	4

These feelings of being alone and cut off are seen by one participant as both a sign of the condition and as exacerbating the depression:

> *At my most depressed; I isolate myself. That's when I know for sure that I'm depressed as I don't want any contact with friends. I'm not sure if it's because I don't want to burden them or because I want to be alone. But I do intentionally isolate myself and I know from experience that I recover much quicker when I am not alone. I do enjoy my own company a lot of the time but this intensifies when I'm depressed. (P12)*

Feeling cut off and isolated (and isolating oneself) seems to be linked with a holding in or masking of the experience:

> *I am good at putting on a front – I have had to do this as a child in order to protect myself and it has become such a force of habit that it is almost impossible for me to admit to anyone that I am feeling down… It is awful to feel so bad on the inside but feel that it is not OK for me to express this externally. The more hurt I feel on the inside the more I try to put on a calm and brave face but actually all I want is someone to notice and for it to be OK to break down in tears and get support. (P4)*

Possibly linked to this in some way, is a sense that others don't know or can't properly understand what is happening:

> *Everyone tries to say that they understand but it just doesn't seem like they do at all. (P30)*

> *I just feel that no-one understands me, even those who are close to me and do understand me. The 'black hole' in the middle of my tummy swallows up any kindness that is shown to me – that is, if I am even able to let the kindness in. I can feel like I am the only person on this planet… I don't feel the same as anyone else and therefore how could anyone else possibly understand me. (P4)*

There is also an avoidance of other people in order to avoid making them feel depressed as well:

53	I avoid seeing other people because I know I'll make them feel bad too	3

I don't like making people feel rubbish and bringing them down with me. (P30)

Combined with feelings of isolation and separation are feelings of hopelessness (17: 3), a lack of control over thoughts and feelings (27: 4, given the joint highest score among all factors, with Factor 2) and a strong rejection of not being helpless (26: -4, the lowest score of all factors for this statement). These three aspects indicate a strong sense of not being able to get out of the experience, of not being to help oneself, including a rejection of getting some sunshine as being in some way curative:

37	I am aware that I need to get some sunshine	-3
26	I know that I'm not helpless, I can get myself out of it	-4

I don't want to go out, shower or get dressed, let alone get some vitamin D! (P12)

Indeed, both statements 26 and 37 above are distinguishing statements for this factor, and reinforce this central sense that nothing can help to alleviate or halt the experience. This is also reflected in the following negatively placed statement:

38	Although it's difficult right now, I know it's part of the cycle of life	-4

I feel there's no end to how I'm feeling so I never get this sense. (P12)

Moreover, this is the only factor where statement 10 concerning self-harm is given a positive placement and is also another distinguishing statement, (it is strongly negatively placed on all other factors):

10	I intentionally injure my body, for example cutting or burning my skin	2

Although this is a weak agreement it indicates that some intentional self-harm could be associated with this particular experience of depression.

There are also feelings of sadness and emptiness **(11: 4)**, meaninglessness (42: 3), a diminished ability to concentrate **(14: 3)**, and a questioning of the point of living (41: 4):

> *I experienced a trauma as an adult and since then I have realised just how shit life is and how awful human beings are and it has led me to really question the point of existing – I do lots of really positive things and most people would say I am a good person but it all seems so pointless to me as most people have a terrible life and at the end of it all that happens is we die. (P4)*

Table 6-20 Lowest scoring statements for Factor 6

Number	Statement	Grid
26	I know that I'm not helpless, I can get myself out of it	-4
38	Although it's difficult right now, I know it's part of the cycle of life	-4
29	I find myself taking many more risks than I would normally	-4
21	**I experience a decrease in my appetite nearly every day**	-4
36	I am aware that it is a result of a physical illness	-5
45	Anti-depressant medication really helps me	-5
46	I cling to the belief that there is a God who cares	-5

This factor is also characterised by a strong rejection of a causal physical illness (36: -5), the efficacy of anti-depressant medication (45: -5) and comfort in a belief in God (46: -5). Here this rejection of Faith as a comfort does not equate to a non-belief in God but rather appears to be another manifestation of helplessness and hopelessness:

> *I believe in God and religion is important to me but I don't bother praying to or speaking to God when I'm depressed and I certainly don't feel in touch with God when I'm feeling depressed. (P12)*

There is also disagreement with the DSM symptom of losing one's appetite **(21: -4)**, describing the experience as the 'blues' (34: -3) and becoming more aggressive when depressed (15: -3):

> *I am not an aggressive person in any way and having experienced an aggressive mother it is the last thing I will ever allow myself to become. When I feel hurt I tend to swallow down the anger, and translate it into*

passion for the things I believe in… I don't think I feel anger very much but I am sure my therapist would say I am suppressing it – but I don't know. (P4)

For this factor, once again, the DSM statements are fairly well distributed throughout the grid. Interestingly, here the DSM statement regarding thoughts of death and suicide is placed at 0:

19	**I experience recurrent thoughts of death and of taking my own life**	0

This may indicate that either this 'symptom' is not important in this experience or possibly that there is some ambivalence to this issue. This is the only factor where this statement appears at 0 and it is not entirely clear how this fits with the wider experience. Overall, only three of the DSM statements have strong salience for this factor - feeling sad and/or empty **(11: 4)**, diminished ability to concentrate **(14: 3)** and a rejection of decreased appetite **(21: -4)** - suggesting a limited relevance for the diagnostic criteria for this experience of depression.

In summary, this factor represents an experience of depression where feelings of isolation, feeling cut-off from others, not wishing to burden others (and avoiding seeing others), and hiding and masking the depression are central, combined with a feeling that others don't properly understand what is happening. In addition to this deep sense of isolation, there are feelings of sadness and emptiness, a sense of hopelessness and helplessness and of not being able to take control of one's thoughts and feelings. Here there is also some limited agreement with intentional self-harm as forming part of this experience. In contrast, there is a strong rejection of depression as being caused by physical illness, of the utility of anti-depressant medication and of taking comfort in a belief in God. There is also rejection of labelling this experience as the 'blues' and of a connection with

increased aggression. Overall, this form of depression appears to be one of alienation - where feelings of distance, separation, withdrawal and isolation are central - combined with a sense of helplessness and hopelessness, a strong feeling that nothing can really help to alleviate the depression.

6.3.7 Factor 7: The 'blues'/surviving through self-reliance

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**
10	48	12	**13**	**14**	1	9	**11**	3	6	18
19	50	**21**	27	17	2	16	15	24	26	34
58	55	**22**	33	29	4	20	38	28	37	43
	56	31	45	30	5	25	41	49	46	
		36	47	32	**7**	39	44	52		
			53	35	**8**	40	51			
				42	**23**	57				
					54					

Figure 6-8 Factor Array for Factor 7

Three participants were associated with this factor, two males and one female, all a similar age (48-50). Two were White /British and one White/Polish, all identified their depression as mild and none had ever been diagnosed or taken prescribed antidepressant medication.

Table 6-21 Biographical details of participants who exemplify Factor 7

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
10	Female	48	White/Polish	No	Mild	No
20	Male	48	White/British	No	Mild	No
33	Male	50	White/British	No	Mild	No

Factor 6 represents an experience of depression which is best described as the 'blues' (34: 5).

Table 6-22 Highest scoring statements for Factor 7

Number	Statement	Grid
18	However bad it gets I know that I have to survive and get through it	5
43	Rather than burden others, I try to fix my problems for myself	5
34	My feelings could be best described as the 'blues'	5
37	I am aware that I need to get some sunshine	4
6	It feels as though the normal rhythm of my body clock is seriously disrupted	4
46	I cling to the belief that there is a God who cares	4
26	I know that I'm not helpless, I can get myself out of it	4

Here Participant 33 rejects the experience as being 'genuine depression':

> *Does not feel like a genuine depression but more like a feeling of negativity. (P33)*

In some contrast to the 'blues' in Factor 2 however, this experience is very much concerned with surviving the difficult feelings (18: 5):

> *I have to carry on as I have others to consider so cannot let negative feelings take hold (P33).*
>
> *I get upset and angry when I experience depression – at times it feels as if I am losing control over myself and everything around me, in fact to cope better I tend to try harder in terms of controlling things in a different way. (P10)*

Helping oneself, not burdening others and fixing problems for oneself (43: 5) are also key aspects of this experience. Here two participants describe their self-reliance which includes taking responsibility for oneself and the possible consequence, for Participant 10, that self-reliance may engender loneliness and greater despair:

> *Only I can get myself out of a depression (only ever experienced a very mild form). There's no point taking medication, you have to snap out of it, and taking responsibility for yourself is one key way. Exercise, social contact have always worked. It's not as if this has been an immediate fix or realisation that the solution lies with me, but the penny drops at some point. (P20)*

I tend to feel reluctant, perhaps even ashamed to tell others how I really feel when I experience problems, and I would rather try to resolve an issue on my own. This often leaves me feeling lonely and more desperate. I end up feeling anxious and guilty and angry with myself. (P10)

This focus on self-reliance is mirrored by strong agreement concerning not being helpless and the ability to get oneself out of the depression:

26 I know that I'm not helpless, I can get myself out of it 4

There is always help to turn to. (P33)

Furthermore, self-help appears to some extent to preclude professional help, reflected in some agreement that professional help will not be useful:

44 Professional help is the last thing I need 2

Mainly because I never suffered from a full blown depression. Self-awareness helps you to look at yourself and why this is happening to you so no need for professional intervention. (P20)

Combined with this emphasis on self-help, self-awareness and dealing with your own problems is a strong sense that the depression is a result of some bodily disturbance or not getting enough sunshine:

37 I am aware that I need to get some sunshine 4

6 It feels as though the normal rhythm of my body clock is seriously disrupted 4

Indeed, statement 6 above is the only distinguishing statement for this factor and this reinforces the central notion here of a sense of disruption to the normal workings of the body, or both body and mind together:

When I experience low mood I often cannot sleep and feel excessively hungry or lose an interest in food. I tend to feel very anxious during such times as if it was something wrong with me psychically/mentally even. (P10)

Linked with this key recognition of the ‘blues’ as something natural or physiological, based in bodily disturbance, is a sense of the experience being part of the ‘cycle of life’, implying the ‘blues’ may come and go:

38	Although it's difficult right now, I know it's part of the cycle of life	2

In addition, there is fear of being judged by others (49:3), a concern over the effect of the depression on family and close relationships (52: 3), a feeling that others may think the depression is selfish (24: 3), and some loss of normal self-control (28: 3). For participants associated with this factor there may also be some comfort taken from a belief in a God who cares (46: 4) and some feeling of sadness and emptiness much or all of the day **(11: 2).**

Table 6-23 Lowest scoring statements for Factor 7

56	I find it hard to distinguish what's real and what I've imagined	-4
48	I feel unsafe in my house, at work, everywhere	-4
50	I'm not able to trust my senses, memory or my judgement	-4
55	I feel more anxious because I don't know what's causing it	-4
19	**I experience recurrent thoughts of death and of taking my own life**	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5
58	I experience bizarre thoughts and delusions	-5

There is strong rejection here of what I have termed the more ‘psychotic’ aspects of depression; the experience of bizarre thoughts and delusions (58: -5), feeling unsafe at home and at work (48: -4), not being able to trust one’s senses (50: -4) and finding it hard to distinguish between what’s real and imagined (56: -4).

Alongside these there is a very strong rejection of thoughts of death and suicide as figuring in the experience **(19: -5)**:

I have never had a thought of taking my own life and I find it difficult to imagine what it must be like. I think it is an extremely painful issue and I feel very disturbed and sad when I hear someone talking about taking their own life. (P10)

There is also a very strong rejection of intentional self-harm as figuring here (10: -5):

I cannot imagine harming myself and I have never experienced a need to do it. I cannot imagine what it must be like for a person to do it. On the one hand I find the idea repulsive, on the other hand I feel a pain and sadness when thinking about this. (P10)

Never had a depression that was serious enough to even start contemplating this. Self-abuse is an abhorrent idea that only leads to an ever downward spiral of self-hate and a likely inability to emerge from the depression. (P20)

At the same time, there is some rejection of the helpfulness of antidepressant medication which appears to fit with a strong feeling of self-reliance:

45 Anti-depressant medication really helps me -2

I have too much knowledge that anti-depressants are a nightmare to come off, and I would be labelling myself a depressive if I ever felt the need to take them. I would rather try physical activity to try to heal the mental issues I was dealing with in the event of a depression. (P20)

The DSM statements do not appear to figure that significantly in this factor. While there is a very strong rejection of recurrent thoughts of death and suicide **(19: -5)** concomitant with the description of this experience as the 'blues', only one DSM statement was agreed with **(11: 2)**, five statements were rejected (-1 to -5) and three were placed in the 0 column. So, again here the DSM diagnostic criteria do not appear to be able to properly capture this experience of depression.

In summary, this experience of depression is characterised as the 'blues' and a need to survive the experience and fix one's own problems lie at the heart of it. There is also fear of being judged by others and the prominence of concern over the effect of the depression on others, including a fear that others may see the

depression as something selfish. In addition, here there is an understanding of this form of depression as resulting from some kind of disturbance or disruption of the body and its rhythm, and that the depression is part of the 'cycle of life'. For some who experience this type of depression there is comfort in a belief in a God who cares and there are also fears about being judged along with some loss of self-control. The DSM statements do not appear to figure that significantly in this factor, although there is a strong rejection of thoughts of death and suicide and some agreement that feelings of sadness and/or emptiness form part of the experience. Overall, this experience of the 'blues' is something participants who are associated with this factor see as manageable through self-help and self-reliance – though where self-reliance may lead to loneliness and greater despondency - and as resulting from physiological or bodily disturbance. There are also feelings of sadness and fear about the impact of the depression on others and about others' judgements.

6.3.8 Factor 8: Loss of meaning/depression as part of the cycle of life

Least like me when depressed — Most like me when depressed

-5	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**
10	45	29	3	**7**	4	1	5	2	12	9
21	48	36	24	**14**	16	6	**11**	**8**	17	38
46	49	51	33	**19**	26	**23**	15	**13**	28	42
	58	52	47	20	30	27	25	18	41	
		56	50	**22**	31	32	39	40		
			53	54	34	35	55			
				57	37	43				
					44					

Figure 6-9 Factor Array for Factor 8

Two participants loaded significantly on this factor, both female, however only one participant gave any further biographical details. Participant 2 is White/British, identified her depression as moderate, has been diagnosed with depression and has taken prescribed anti-depressant medication in the past.

Table 6-24 Biographical details of participants who exemplify Factor 8

Participant	*Gender*	*Age*	*Self-identified ethnicity*	*Diagnosed?*	*Self-identified severity*	*Prescribed antidepressant medication?*
2	Female	40	White/British	Yes	Moderate	Yes, in the past
27	Female	None given	None given	None given	None given	None given

Factor 8 represents an experience of depression in which a sense of meaninglessness is central (42: 5), along with feelings of hopelessness (17: 4), a questioning of 'what is the point of life?' (41: 4) and a dwelling on what has been lost (12: 4).

Table 6-25 Highest scoring statements for Factor 8

Number	**Statement**	**Grid**
38	Although it's difficult right now, I know it's part of the cycle of life	5
9	I have little or no interest in sex	5
42	My life and the world seem meaningless	5
12	I find myself dwelling on the things that I've lost	4
17	I feel as though everything is hopeless	4
41	I find myself wondering 'what's the point of my life?'	4
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	4

One participant associated with this factor describes feeling cut off from the world, where part of this disconnection is a loss of interest in sex (9: 5):

> *Depression cuts me off from the world and the people in it. I feel disconnected from everything. Numb would be a good word to describe it. [Loss of interest in sex] is a further expression of disconnection from the world around me. (P2)*

In addition to a sense of meaninglessness there is also a discontinuity between what is happening on the inside and what is showing on the outside (2: 3) and a decrease in normal self-control (28: 4), combined with a sense of having to survive the experience (18: 3). Alongside these aspects, there is a loss of interest

and pleasure **(13: 3)**, an experience of fatigue and/or loss of energy **(8: 3)** and, to a lesser extent, feelings of sadness and emptiness **(11: 2)**.

The centrality of meaninglessness and hopelessness in this experience appears linked with a rejection of the sense that this depression is a result of a physical illness (36: -3). However, this is not straightforward and there is here what appears to be a more complex understanding of the relationship between mind and body, including a questioning of which comes first:

> *I don't think in terms of the physical/mental – I view myself to be a totality of mind/body/spirit (whatever that is), and changes in my mood are not solely the result of the physical. However, I always wonder about the chicken and egg question, especially with regards to food – when I overeat, or eat unhealthily I find this to strongly affect my mood and my hormonal/chemical levels. But I overeat when I already feel down, so it's difficult to know what came first. I find that I cannot separate myself into compartments. (P27)*

Despite the difficult feelings, for example of meaninglessness and hopelessness, which are associated with this factor, there is very strong agreement that the experience is part of a 'cycle of life' (38: 5), indeed this statement is one of two distinguishing statements for this factor. Here Participant 27 describes her acceptance of 'up's and 'downs' as part of her existence:

> *I have learnt that these up and downs have always been, and I imagine will always be, simply inherent to my existence. There doesn't seem to be a way around it, and this cyclical way of being is mirrored in nature. Having read a lot of Eastern philosophy, I try to appreciate all of life. (P27)*

Moreover, as well as questions concerning meaning, including 'the point of my life', there is also a desire to find answers concerning the depression itself (40: 3):

> *Because I believe understanding the science of why depression happens would make it easier for me to deal with it and work out ways to help myself. (P2)*

Table 6-26 Lowest scoring statements for Factor 8

48	I feel unsafe in my house, at work, everywhere	-4
45	Anti-depressant medication really helps me	-4
58	I experience bizarre thoughts and delusions	-4
49	I fear being judged if I tell others about it	-4
46	I cling to the belief that there is a God who cares	-5
10	I intentionally injure my body, for example cutting or burning my skin	-5
21	**I experience a decrease in my appetite nearly every day**	-5

There is very strong disagreement with a symptom of decreased appetite **(21: -5)**, for participants associated with this factor, but where over eating is a problem rather than loss of appetite:

> *When I'm depressed, the first thing I turn to is food, and experience a large increase in appetite! (P27)*

The relevant DSM diagnostic criterion includes over-eating as well as under-eating (significant change in weight or appetite), and therefore has clear relevance for this aspect of the experience.

As with some other factors there is generally strong rejection of what might be termed the possible 'psychotic' aspects of depression:

48	I feel unsafe in my house, at work, everywhere	-4
58	I experience bizarre thoughts and delusions	-4
56	I find it hard to distinguish what's real and what I've imagined	-3
50	I'm not able to trust my senses, memory or my judgement	-2

There is also a very strong rejection of intentional self-harm as figuring in this experience (10: -5):

> *This is not something I have ever experienced or felt inclined to do. (P2)*

There is also a strong rejection of the fear of being judged and this is the second of the distinguishing statements for this factor (49: -4), having been given a

much more negative score in comparison with all the other factors, and possibly related to this is a rejection of feelings of shame with regard to this depression (51: -3). Here then, shame and fear of judgment do not figure significantly for participants experiencing this form of depression and this is unusual in comparison to the other factors.

In addition, there appears to be a very strong feeling against the idea of a belief in God as a comfort (46: -5), which is shared with Factors 4 and 6:

I have no religious beliefs at all. (P2)

The placement of DSM statements for this factor is quite variable, with agreement with four statements and disagreements with five. Interestingly, the statement concerning thoughts of death and suicide **(19: -1)** is given a low score here, (this is one of only three factors with low scores for this statement), so that it is only very mildly rejected.

In summary, this experience of depression is characterised by feelings of meaninglessness, hopelessness and a loss of pleasure and interest in life, including a loss of interest in sex. There is a questioning of the point of life, a loss of normal self-control, a dwelling on what has been lost and a need for some answers to the question of why this is happening. Combined with these there is also a sense of having to survive the experience along with a strong sense that the depression is a part of the cycle of life. In addition, there is a strong rejection of the symptom of decreased appetite (where an increase in appetite appears to be a major element of this form of depression), intentional self-harm and comfort taken from a belief in a caring God. There is also strong rejection of a fear of being judged and rejection of the potentially ‘psychotic’ aspects of depression. Overall, this experience of

depression is one of a loss of meaning, hope and pleasure in life. There is also a linked questioning here of the point of life and a dwelling on loss, combined with a sense of depression as part of existence and only a mild rejection of thoughts of death and suicide.

6.4 Summary of Results

This Q-methodological study yielded eight interpretable factors each of which represents a different experience of depression shared between at least two participants. There is significant diversity between these different experiences which includes; 1) an experience that resembles 'clinical'/major depression as reflected in the DSM diagnostic criteria, 2) an experience of the 'blues' in which overcoming loss and bereavement are central, 3) an 'anti-clinical' experience of depression in which anxiety plays a major role, 4) an experience of depression where feeling emotionally devoid and empty is combined with strong feelings of isolation, 5) an experience with sadness and loss at the core where a need to survive the depression is an overriding feature, 6) an experience of depression with feelings of alienation and helplessness at its heart, 7) an alternative experience of the 'blues' where self-reliance and self-awareness are central, 8) an experience where loss of meaning and hopelessness come to the fore, along with an acceptance of the mood, and the up and downs associated with it, as part and parcel of existence.

Examples of the many significant variations between these experiences include: differences in immediate symptoms, for example the extent to which sadness and emptiness or diminished interest or pleasure are major symptoms; differences in vocabulary, where two of the experiences are referred to as the 'blues' rather than depression; differences in the relational aspects of the depression,

including a sense of isolation, feeling cut off from others and feelings of shame and fear of being judged; differences in the perceived role of the body and physiology and the relationship between body and mind; differences in feelings about what might help or alleviate the depression; different senses concerning whether depression is an illness and/or part of the 'cycle of life' and existence; different feelings about the efficacy of antidepressant medication and professional help and differences in the sense of how the depression has come about and how it feels to not know what the cause or causes might be. What is also important here is that those aspects of the experience which are not obviously immediate 'symptoms', for example feelings about the causes of the depression and the different possibilities for alleviation and/or treatment, appear intricately bound up with the overall lived experience of depression for the participants in this study.

Furthermore, the range of experiences found here evidence very different patterns of relationship to the received DSM-5 diagnostic criteria for major (or 'clinical') depression. While Factor 1 provides strong evidence that for some participants the DSM criteria would successfully identify their depression, (and in this factor the risk of suicide appeared to be greatest), for the other factors the diagnostic criteria (DSM statements) were more dispersed, where an alternative picture to that presented by the received diagnostic criteria emerged. Thus, it could be argued that if one key purpose of the DSM criteria is to identify those persons with depression who may be most at risk of suicide then this study appears, to some extent, to support those criteria, indeed the statement concerning thoughts of death and suicide is a distinguishing statement for Factor 1. In this regard, it is also important to acknowledge that there are several other aspects to the DSM diagnostic criteria including the level of distress caused by symptoms, the absence of a medical

condition or the effects of a substance, and the absence of schizophrenia, mania and other ‘psychotic’ disorders. Therefore, the nine DSM statements included in this study do not represent the whole diagnostic picture although they do represent the key symptoms used for diagnosis.

Of the remaining seven experiences however, none would be identified or recognised as ‘major’ by the occurrence of a minimum of five of the nine diagnostic criteria (where one of these must be either depressed mood or loss of interest and/or pleasure). Here I suggest that while the experience represented by Factor 1 appears to most closely resemble ‘clinical’ or major depression, the other factors also include experiences where there is a great deal of pain and distress and for some of these experiences this pain and distress may be very severe. Moreover, although the DSM statement concerning thoughts of death and suicide was most agreed with (and distinguishing) in Factor 1, there was only mild disagreement with two factors (Factors 4 and 8) and either neutrality or ambivalence concerning it with a third (Factor 6). Further research would be needed to assess the nature and severity of suicidal thoughts for these other experiences, however it is possible that the DSM criteria may well miss other types of depression where there may still be some risk of suicide and/or self-harm (for example with Factors 4, 6 and 8).

Most importantly though, beyond this immediate issue of the risk of suicide, this study has shown that the term ‘depression’ is used and understood by participants to describe very different forms of low mood or intense sadness. This finding casts some doubt on the abnormal/clinical psychology practice of diagnosing depression to the extent that many other experiences of depression (here 7 distinct experiences), some of which include severe negative emotional states, may be rendered less visible or even invisible when examined though the received

medical/DSM/ICD diagnostic lens. Moreover, adopting a relatively singular and fixed understanding of the complex phenomenology of depression may also pathologise one experience over others, or alternatively trivialise or downgrade some very severe and difficult experiences because they do not conform to a notion of 'serious' or 'clinical' depression. Indeed, there are complex issues raised by these findings concerning the intentional and unintentional pathologisation of depression and the extent to which the abnormal/clinical psychology model is of use in capturing such a complex, relational, phenomenon such as depression given much of the phenomenology may be overlooked or even discounted in the diagnostic process. In the following final chapter, I discuss these issues and the findings in more detail, referring back to the conceptual frameworks discussed earlier in the thesis and to debates concerning the identity and professional status of counselling psychology.

6.5 Personal Reflection

Explicating and interpreting the factors reported in this chapter was both a challenging and a rewarding task given the high number of interpretable factors and the range and number of statements included in this study. Interpreting factors in this kind of research is a complex enterprise requiring analysis both within the pattern of sorting for each factor and through comparisons across all the eight factors. There are also the distinguishing statements to be included along with the follow-up comments from participants. Despite these challenges I very much enjoyed, and felt rewarded by, the process of making sense of the results and bringing the different experiences to life as best I could, trying to be as fair as possible to the placing of statements and the written descriptions of depression given by participants.

Analysing and interpreting the factors also had a strong emotional impact on me. Many of the follow-up comments and descriptions were very moving and I found that as I was working on this chapter and becoming immersed in the often difficult and sometimes harrowing experiences of participants – the same was true when I was reading and reviewing the autobiographical accounts of depression for the literature review – I felt at times sad, low and depressed myself. This was in part because working with participants' descriptions of their depression and sad moods brought up my own feelings of sadness and my own recollections of times when I had been depressed and had struggled with difficult events in my own life. At the same time I also experienced strong feelings of gratitude that so many of the participants in the study had been so open and honest about their own experiences. Without their frank comments it would have been very difficult to get a proper sense of the different experiences that emerged from the factor analytic procedure. Also in this regard, I struggled at times with the analysis when there were few and/or shorter comments and this shows through at times in the explication, more detailed comments bring the factor to life in a way that is not possible where the comments are less detailed or partially absent.

My own Q-sort (Participant 3), although not exemplifying any of the factors, correlated with Factor 8, and the experience represented by that factor – especially a loss of meaning and feelings of hopelessness - really resonates, including the increase in appetite which I always experience when I feel depressed. From a personal perspective this helped to validate the procedure for me given that this factor so clearly spoke to my own experience of depression which I also discovered was, to a great extent, shared with the two participants statistically associated with it. This helped me feel that I was on the right track with my analyses. However, it is

important to state that the results reported here are interpretations and, although I have aimed to ground those interpretations as firmly as possible in the quantitative and qualitative data, as I have argued earlier any ‘description’ is always already an interpretation bound up with the social and cultural meanings that I have drawn upon (including those which have already shaped me) and my own personal beliefs, feelings and experiences. In this sense although the main method in this thesis is quantitative, the methodology is very much qualitative; where the researcher’s subjectivity and their (inevitably personal) interpretations, rather than statistical procedures, lie at the heart of the analysis.

Chapter 7 Discussion

7.1 Introduction

In this final chapter I begin with a review of the overall findings and then move on to discuss the results with regard to the social constructionist framework reviewed earlier in Chapter 2. I then present an existential-phenomenological interpretation followed by a discussion of the implications of the study for existential-phenomenological counselling psychology practice. I go on to discuss my sense of what counselling psychology means for me and lastly, I review the strengths and limitations of the study, suggest some possible follow-up research and give a final personal reflection.

7.2 Overall Findings

The key aim of this thesis was to uncover the complexity and variety of participants' experiences, starting with a very open definition of depression operationalised in a Q-set of 58 experiential statements. Each of the eight factors found in this study represents a distinctive but shared form of experiencing depression. Principal components factor analysis produces factors which are orthogonal, meaning that they are entirely statistically independent and therefore not correlated with each other. This orthogonality is also evidenced in the factor explications where it can be seen that each different factor/experience is characterised by a different focus, a diverse sense of what is at the heart or the core of the depression, along with an equally diverse sense of what the experience is not.

Of the 58 statements only one consensus statement emerged (statement 56) which indicates that the Q-set enabled meaningful differentiation between divergent experiences. There were also 19 distinguishing statements so that 33% of the Q-set

enabled statistically significant differentiation between experiences. Thus, using the Q-set, participants were able to express their own experience of depression in a way that enabled both a statistical and a qualitative/interpretive differentiation between the participants and their different (shared) experiences. The detailed presentation of the results in the previous chapter shows just how varied the experience of depression can be, how the same term or category can be used to represent and communicate very different lived experiences.

The range of experiences found here also evidences very different patterns of relationship to the received DSM-5 diagnostic criteria for major (or 'clinical') depression. Factor 1 was the only factor where six DSM statements were agreed with (four strongly agreed with, and two less strongly agreed with). Given the DSM criterion of at least five of the nine diagnostic criteria being present where one is either feeling sad and/or empty much or all of the day (statement 11) or markedly diminished interest or pleasure (statement 13), those participants associated with this factor would be likely to be diagnosed with clinical depression if they sought medical/clinical psychological help. The distinguishing statement for this factor concerns recurrent thoughts of death and suicide (statement 19) and this also fits with a clinical picture of depression where suicide may be a serious risk. 'Mild' and 'moderate' depression tend not to be seen to have as high a risk of suicide and therefore Factor 1 may well represent something like 'severe' depression as understood within the ICD criteria. In this way Factor 1 can be argued to roughly correspond to the 'clinical' phenomenology for major depression found within the DSM.

None of the other factors fit the DSM diagnostic criteria in the same way as Factor 1, although one (Factor 3) showed a strong rejection of the DSM statements,

displaying disagreement with 6 DSM statements (five strongly disagreed with and one less strongly), indicating some resonance with the clinical/abnormal psychology picture of depression albeit through a rejection of it. Thus, it could be argued that Factors 2-8 could be categorised as 'non-clinical' depression, however as I stated in the previous chapter, while two of the factors reveal an experience of depression that participants labelled as the 'blues', some of the other factors, especially Factors 4, 6 and 8, disclose experiences that appear to be severe, where there is much pain and distress. Moreover, there was only mild disagreement with statement 19 (recurrent thoughts of death and suicide) with two factors (Factors 4 and 8) and either neutrality or ambivalence concerning it with a third (Factor 6), indicating at least the possibility that suicide could still be a risk with these experiences. Furthermore, while 3 of the 4 participants associated with Factor 1 had been diagnosed with depression, there were four other factors (Factors 2, 4, 6 and 8) where at least one of the participants who were associated with the factor had been formally diagnosed with depression. Likewise, while participants loading on Factor 1 all self-identified their depression as either moderate or severe, five of the other factors (Factors 2, 4, 5, 6 and 8) were also associated with at least some participants who identified their depression as either moderate or severe. This suggests that distinctions between 'clinical' and 'non-clinical' and 'mild', moderate' and severe' depression are not so clear cut and that although not necessarily falling into the DSM/ICD diagnostic net, some of the experiences of depression found here may be self-identified and experienced as moderate or severe episodes nonetheless. Given this, the results provide some evidence that clients' own experience and portrayal of their depression may sometimes be at odds with a more abnormal and clinical psychological/nosological account.

I argue here that these findings call into question at least some aspects of the medical/clinical psychological practice of diagnosing depression to the extent that several other experiences of depression, some of which include severe negative emotional states, are rendered less visible or even invisible when examined though the received DSM nosological lens. Moreover, adopting a relatively singular and fixed understanding of the complex phenomenology of depression may also pathologise one experience over others, or alternatively trivialise or downgrade some very severe and difficult experiences because they do not conform to a notion of 'serious' or 'clinical' depression. The findings of this study therefore put into the spotlight the extent to which we should rely on the received diagnostic criteria for depression in counselling psychology practice. Those diagnostic criteria may well be of use in identifying clients with depression who are experiencing a severe episode and who may be at higher risk of suicide, however these results show that the term 'depression' - as a category and means of communicating an experience - can include experiences which do not fit into the received diagnostic criteria but appear to be severe nonetheless. It could be argued that adopting a fairly fixed and narrow picture of depression may be appropriate for medical practice and/or clinical psychology, where the aim is to accurately identify a clinical/medical phenomenology and to subsequently provide appropriate intervention which may include (in medical practice) the prescription of medication. However, in counselling psychology practice we are likely to encounter the whole range of depression experience and very liable to miss the lived reality and meaning of depression for clients if we rely on too narrow a definition or understanding or hold 'clinical' depression as the only serious, severe, high-risk form.

It is also important to remember that each of the eight experiences uncovered in this study are experiences which are shared between at least two participants, Q-methodology is precisely aimed at uncovering shared experiences within a particular sample. This means that the factors/experiences, while evidencing divergence from each other, also represent an experience which has meaning and relevance beyond the level of one individual. Moreover, while the purposive and snowball (non-probability) sampling utilised in this study means that there must be great caution used in considering the extent to which these results can be more widely generalised, it can reasonably be argued that these eight factors/experiences may exemplify some forms and modes of experiencing depression found within the wider (UK) population and possibly beyond. I am not suggesting that these results are necessarily directly or straightforwardly generalisable but rather that they may give an overall snapshot of some of the different and diverse elements and aspects of the ways persons experience their depression found in wider populations. In this way, the findings may well be of use for practitioners and as a basis for further research, which I discuss later in this chapter.

7.3 The social construction of depression

In this section I return to the social constructionist conceptual framework of the thesis in order to further interpret and discuss the results. In Chapter 3 I reviewed some key literature related to the lived experience of depression and concluded that the social historical and cross-cultural writing and literature revealed the socially constructed nature of depression. Put another way, this work shows that our conceptions of depression have changed significantly across time and have been bound up with many different social and moral orders, culminating in the dominance of the current bio-medical understanding in the West. Likewise, that research shows how culture

(cultural structures and processes) greatly impacts on the experience of depression which varies across cultures and continents. I also contrasted the autobiographical accounts with the abnormal/clinical psychology understandings of depression as an 'affect' or mood disorder and argued that the abnormal psychology understandings appear narrow and limited when placed alongside the first person accounts. Here the results of this study also suggest that the abnormal/clinical understandings appear too fixed and narrow to fully capture the diversity of experience revealed in this study. I now wish to discuss this notion of the social construction of depression in more detail referring back to the work reviewed in Chapter 2.

I suggested there that social constructionism offers at least four key critiques of mainstream psychological theory and practice and I will make use of each of those critiques in order to explore the utility of this conceptual framework in making sense of the results of this study. Firstly, I suggested that social constructionism has played a role in dismantling modernist (realist, empiricist) ideas of truth and objectivity, where there is a questioning of the notion that there is a real, discernible world 'out-there' that can be accessed directly through the senses and is separate from and impervious to our experiences, understandings and interpretations of it. Rather, social constructionism asks us to understand reality as socially constructed, meaning that what we take to be real and true (including how we directly experience the world) is a reflection not only of the intra-psychic realm but also of complex historical, social, cultural and political-economic processes which, to a great extent (though never fully), shape and construct our lived, embodied experience. As I have previously argued, from such a perspective we would expect a variety of understandings and experiences of low mood, found not only across time and culture but also at the personal, individual level as persons draw from a range of 'repertoires

of social practices' (Harré, 1986: 4) to make sense of and to convey their experiences. In this sense, the results of this study problematise both the narrow, to some extent culture-blind and restricted 'truth' of the abnormal/clinical psychology accounts of depression and the nosological practice of dividing depression into 'clinical' and 'non-clinical' categories. As stated earlier, some of the experiences of depression uncovered here which do not fit the accepted abnormal psychological understandings, appear to be as severe as the 'clinical' form and, moreover, it appears that for some of the factors that do not fall into the standard diagnostic net, a risk of suicide cannot be ruled out.

Many of the participants associated with Factors 2-8 had been previously diagnosed which may indicate that the diagnostic criteria are being more loosely applied and that the safety-net of diagnosis still captures persons who may not fall into the standard diagnostic categories. Alternatively, it could be argued that the diagnostic criteria are inconsistent (or inconsistently applied) and/or that they are unnecessarily resulting in pathologising/medicating persons with depression. Above all however, I suggest that the results offer evidence that a dominant (abnormal/clinical psychology) discourse or singular truth of the experience of depression is problematic and difficult to sustain. Rather, we see here multiple (personal but to some extent shared) 'truths' where the importance of 'subjective truth' or 'aletheia' comes to the fore. A stronger argument could be that the abnormal/clinical psychology 'truth' risks casting some persons/clients who are experiencing depression in the role of Other and I discuss this possibility later in the chapter.

Secondly, I suggested that social constructionism asks us to question the representational theory of language that still pervades mainstream traditional

psychology. It might be claimed that the abnormal psychology/psychiatric accounts rely upon a (mainstream) representational theory of language where the description of symptoms is understood as an objective, factual indication of the singular, underlying (possibly causal) reality of the disease or syndrome, evidenced by the description conforming (or not conforming) to the nosological criteria. For the medical/disease model to function language must enable, just as with all natural science, a clear, unambiguous and accurate account of the experience or (medical) phenomenology. Social constructionism shows us that language works in a more complex, constructive, performative way, where it does not enable straight forward or direct access to the reality underneath but is rather subject to many discursive and narrative forces which are in turn shaped and affected by the wider social, historical and cultural context. The variety of accounts found here could be argued to indicate the variety of possible ways of experiencing and constructing what is termed 'depression' but where these personal constructions (and subjective truths) also, to some extent, draw upon and reflect particular stories or discourses (repertoires of social action) that circulate in our culture(s). Thus, any strategy to reduce these experiences/stories to a single valid, 'serious' form will always, intentionally or unintentionally, displace, marginalise or refuse other accounts and experiences. Linked to this notion of stories and 'discursive repertoires' is the idea that, at the personal level, depressed persons may have chosen particular – isolating, separating – propositions/stories from their broader language repertoire such that choice and language-use become combined. As Dorothy Rowe has argued:

> … the person who experiences depression has in his [or her] language structure a group of propositions each of which concerns a way in which he separates himself from other people… Depression is that experience which accompanies the selection from the set of possible states from a person's language structure that particular state or system of

> propositions whereby the person sees himself as being cut off from and as choosing to be cut off from interaction with others. (Rowe, 1988: 30)

Given the study's focus on the diversity of shared experience, the results do not allow any clear conclusion with regard to individual language-use but rather they evidence the possibility of understanding and describing one's depression in varied ways, ways in which the meaning of the depression can profoundly shift and therefore the consequences of that meaning - for example feeling cut off from others and therefore cut off from help - may also shift.

Thirdly, I suggested that social constructionism challenges the individualism of mainstream psychology which adopts a variously explicit and/or implicit version of the person based upon current Western ideas and values. This aspect of social constructionism is more difficult to map onto the results of this study, however it could be argued here that the complexity and multiplicity of experiences found in this study problematises the mainstream clinical/abnormal accounts which tend to situate the depression firmly within the person, within their individual biological, neurological or psychological structures and process. Moreover, we might argue that when participants are given a wide range of statements which include some of the relational and social aspects of the experience of depression, some people report experiences where these aspects come to the fore. This was reflected in differences between the relational aspects among factors, including the sense of isolation, feeling cut off from others and feelings of shame and fear of being judged, and different senses concerning whether depression is an illness and/or part of the 'cycle' or fabric of life. As I argued in Chapter 2, the individualism of mainstream psychology often plays a role in fixing certain problems within persons or groups and in so doing, intentionally or unintentionally, elides or even deletes elements of their origin in the relational world and/or in society and culture itself. This process of individualisation,

in turn, may play a role in the creation and reproduction of oppressive discourses and practices. It cannot be argued here that the results provide strong evidence for this but rather that they indicate that the individualism inherent in medical/nosological models may be difficult and/or problematic to sustain, and this may be especially relevant for existential-phenomenological counselling practice which I discuss later in this chapter.

Fourthly, and linked to three above, I suggested that social constructionism offers a challenge to essentialism in mainstream psychology – most often reflected in psychological explanations which rely on neurological/neurotransmitter, genetic, hormonal, biological and physiological explanations of thoughts, feelings and behaviour. The mainstream abnormal/psychiatric accounts of depression are, by definition, essentialist in nature given their reliance on the bio-medical/nosological/clinical model of disease and 'disorder'. Such essentialism – manifested in psychological typologies - is not necessarily in itself a negative thing but rather should be judged on the consequences, real and/or potential, of such explanations for those with depression, including clients and patients undergoing treatment. Again, it is not possible to make strong claims on the basis of the results of this study, however the way in which the lived experience of depression has been shown here to be multi-faceted and manifold, where several distinct experiences can be communicated and categorised under the same term, would suggest that essentialising the experience may lead to unnecessary pathologisation on the one hand and marginalisation of some experiences on the other. Moreover, the emphasis in abnormal and clinical psychology/psychiatric accounts on biological/physiological causes, and the concomitant practice – based on the 'disease' model - of giving antidepressant medication to address those causes, may well hinder or even prevent

our ability to understand and work with other equally severe and disturbing experiences of depression which may not necessarily be primarily physiological in nature. For some of the experiences reported here, it may, for example, be far better to consider psychotherapeutic treatments which emphasise the relational, situated, context bound aspects of the depression and in a way that avoids abstracting a common version from the multifarious, concrete lived world. In the words of Harré (1986) which I quoted in Chapter 2:

> There has been a tendency among both philosophers and psychologists to abstract an entity - call it anger, love, grief or anxiety - and then try to study it. But what there is are angry people, upsetting scenes, sentimental episodes, grieving families and funerals, anxious parents pacing at midnight, and so on. There is a concrete world of contexts and activities. We reify and abstract from that concreteness at our peril. (Harré, 1986: 4)

It is important to reiterate however, as I have already noted in Chapter 1, that there is a sense in which this study can also be said to be reifying and abstracting the lived experience of depression, categorising it into discrete factors/experiences. However, as I have earlier argued, firstly some degree of reification must always be present in research given the nature of the relationship between narrative, discourse and experience and secondly I would argue that this study is making sense of the experiences in a way that enables participants' voices and experiences to be more clearly heard. For me, it is never possible to gain direct access to lived experience, once that experience is communicated it becomes an account of some kind, although some accounts may get much closer to the lived experience than others – and these are the accounts I have sought in this study.

It can further be argued that the essentialising, individualising nature of abnormal psychology/nosological accounts risks creating and sustaining a form of symbolic violence with respect to the experience of depression and those who

undergo it. Indeed, does the abnormal psychology/nosological model represent a 'self-celebratory monologue' (Sampson, 2008: 4) in which there is a hierarchy, a dominant and subordinate (self-other) aspect to it? Can it be argued that a singular, reduced abnormal psychology/nosological version constructs and defines the Otherness of the 'patient' whose experience is seen to lie outside normal, healthy thinking, feeling and acting and who therefore must be brought back to that normality, back into healthy, civilised citizenship? To what extent does the abnormal/clinical version marginalise, trivialise or even exclude experiences of depression which do not fit the model? Such symbolic violence, where (and if) it occurs, may well exacerbate the experience of depression which I have shown here already includes, for many, a profound sense of not being heard, of feeling cut off from others and therefore from possible help.

The key role of concepts of normality and abnormality, and to some extent 'clinical' and 'non-clinical' categorisations may omit the socio-economic roots of such distinctions which, it can be argued, have more to do with relations of power and authority than with (medical) phenomenology. Here I am not arguing that the results of this study are necessarily able to shed clear light on this complex social and historical aspect but rather that a fuller awareness of the operation of bio-medical discourse requires an understanding of wider relations of power. As Rose (1985: 231) has argued:

> To derive a theory of normality from a conception of the normativity of a life process and the incidence of pathology is one thing. To derive a theory of normality from the normativity of a statistical average and the incidence of variations from it is another… The problem [of psychology's basis in differentiating normal and abnormal] is exacerbated further when what counts as abnormality is set by a norm of adaptation to the conventions of a socio-economic order. Health, for the psychology of the individual, is not so much life in the silence of the organs as life in the silence of the authorities.

Above all, I suggest that the results of this study and the discussion above indicate the importance of rejecting a dichotomous understating of personhood - of placing the individual realm in opposition to the social, relational and collective realm - in favour of a:

> …dialectical interpenetration of subject and object in which neither has full primacy… The person is the mediated product of society and also, in acting, reproduces or potentially transforms that society (Sampson, 1989: 6)

However, the results do not necessarily diminish the possible utility of a clinical diagnosis per se but rather provide useful empirical evidence for the narrowness and limited range of its ability to capture the reality and complexity of depression for some, or even for many, clients.

Finally, while the social constructionist/post-structuralist conceptual framework adopted in this study enables the inclusion of a broader, more contextualised understanding of the experience of depression, as I have already discussed (Chapter 2) social constructionism has clear limits in relation to the extent to which the role of personal experience - and especially the lived body - are in danger of being lost altogether (Burr, 1999). In the next section I more fully consider the ways that existential-phenomenology can help us to make sense of the experience of depression in a form that is useful and helpful for counselling psychology practice.

7.4 An existential-phenomenological approach

The marginalising of lived, embodied experience in social constructionist and some post-structuralist conceptual frameworks mentioned earlier, for me highlights the utility of existential-phenomenology as a way to provide a much needed account and a deeper understanding of lived experience - in a way that might inform and illuminate counselling and psychotherapeutic work with depressed and other clients.

As I have already discussed (Chapter 4), though post-structuralism/social constructionism and existential-phenomenology were elaborated at different historical periods – where post-structuralism to some extent followed and critiqued phenomenology – they can be seen to have major themes and concerns in common. Dreyfus (2004) has argued that there is a rough parallel between the work of Foucault and Heidegger, where Heidegger was interested in the ways in which things become turned into objects and Foucault was interested in the ways in which selves become subjects. Both thinkers, for Dreyfus, seek to show us the 'constructedness' of our existence.

Despite their common themes and shared concerns however, there are still some key differences between these two ways of thinking about, and understanding, our world and the persons who inhabit it. I have already highlighted (Chapter 2) a key difference between the post-structuralist/constructionist rejection of a foundational truth and Heidegger's advancing of a form of existential truth - where for Heidegger (2002) truth is not a representation, but rather 'aletheia', (disclosure/truth) or 'Unverborgenheit des Seins' (a presence or unconcealment of Being). In fact, for Heidegger representational thinking is conceptualised as already covering up this genuine original understanding, which is a mode of existence preceding the objectified mode of the representational subject (Georg, 2016). It is this notion of existential truth that I wish to utilise here in order to make more sense of the lived experiences of depression uncovered in this study.

Heidegger's understanding of mood as a fundamental aspect of how we find ourselves (how the world is disclosed to us) may be one way in which it is possible to expand and deepen the current understandings of depression – both the experiences found in this study and that presented in the received comprehensive

diagnostic systems. Heidegger's key concept of *Befindlichkeit* (attunement), which is existential (or ontological) and which is expressed ontically as everyday feeling or *Stimmung*, indicates that an experience such as depression may reflect some change in the existential or ontological aspect of Being rather than solely the everyday (ontic) feeling. For Heidegger then, there is something underneath our feelings, or put another way, something other than feelings and emotions may potentially be disclosed in the experience of depression; something more than emotions experienced by persons and/or the socially constructed patterns of representation which give shape to them (as in post-structuralism). Thus, when we experience something like the kind of emotions described in the different factors found in this study, we are already deeply rooted in the interpersonal world, we already have a sense of Being-in-the-world which precedes these recognisable feelings, we are already 'there', but this Being-there is difficult to recognise or reflect on as it forms the very fabric which is necessary for us to have any lived experience (or representations) at all.

Matthew Radcliffe has written extensively, and very usefully, on developing an existential-phenomenological understanding of depression and argues that in depression it is not only that we experience certain kinds of feelings (shown in some detail in the results of this study) but that we may also, and at a deeper existential/ontological level, find ourselves in a profoundly different realm where there is a 'shift in the sense of belonging to a shared world' (Ratcliffe, 2013a: 5). Ratcliffe (2015) suggests that there is some evidence for this in the fact that many persons who have experienced depression find it difficult and sometimes impossible to put the experience into words, something described earlier in Chapter 3 and

reflected in the results of this study, especially with Factor 4 'emotionally devoid/isolated depression'. As Ratcliffe (2013a: 3) suggests:

> …we might ask, why is depression so hard to understand? The first thing to appreciate is that it is not simply a matter of the intensification of certain familiar aspects of experience and the diminution of others, such as feeling more sad and less happy, or more tired and less energetic… One finds oneself in a 'different world', an isolated, alien realm, adrift from social reality… depression involves a radical departure from 'everyday experience'. And it is not a localized experience that one has within a pre-given world; it encompasses every aspect of one's experience and thought – it is the shape of one's 'world'.

Thus, bringing existential-phenomenology to bear upon the experience of depression requires us to understand that some experiences of depression may involve profound existential alterations in our fundamental sense of belonging in or to a world. Indeed, Heidegger asks us to understand that humans *are* their Being-in-the-world-with-others. Moreover, Heidegger's notion of finding oneself in a world (the concept of Befindlichkeit, which is always in relation to *Rede* and *Stimmung*), exists prior to any split (through objectification) between the 'inside' and 'outside', between mind and body or thoughts and feeling. Furthermore, this sense of finding-oneself-in-a-world, also includes a central element of possibility and choice:

> Dasein is not static – it has possibilities. It either finds itself thrown into them or it chooses them, but in either case it can realise them or put them aside. Possibilities suggest temporal frameworks, they *are* not yet but may *be* in the future [original italics] (Cohn, 2002: 9-10).

In relation to the experience of depression, where there can be a profound sense of a lack of hope and a lack of possibility, it could therefore be argued that somehow the usual mode of finding oneself in a world has shifted, where there is a very different sense of the kinds of possibilities we have access to:

> Whereas the non-depressed person might find one thing practically significant and another thing not significant, the depressed person might

> be unable to find anything practically significant. It is not that she doesn't find anything significant, but that she cannot. And the absence is very much there, part of the experience – something is missing, painfully lacking, and nothing appears quite as it should do. (Ratcliffe, 2013a: 5)

Put another way, for Radcliffe there is a key difference in losing hope in particular aspects of one's life or particular tasks or ventures and losing the very facility of hope. Furthermore, conceptualising some kinds of depression as a reflection of a shift in one's Being-in-the-world; of one's sense of connection to others, of having access to possibility and choice, might provide an alternative and useful means of interpreting some of the experiences of depression found in this study. Indeed, paying closer attention to the existential/ontological aspects of depression may provide a means to understand and to work with clients who are deeply depressed without recourse to objectifying and/or pathologising discourses and accounts. I discuss these and other issues relating to practice in the next section.

Finally, in terms of the theoretical framework of this thesis, the notion of subjective truth can be said to provide a vantage point which is in some sense 'outside' of the constructed world but without recourse to a classical metaphysical type or truth which - as has been argued here and previously - could become authoritarian, imposing forms of truth tied up with regulatory practices; forms of truth to be submitted to. Rather, bringing in a notion of existential truth or 'aletheia', through providing a dimension that is not socially constructed, offers the possibility of conceptualising an ontological ground of existence which precedes processes of representation and objectification[7]. Bringing elements of Heidegger's work into social constructionism could be argued to provide one way in which to approach the difficult

[7] I am very grateful to Georg Nicolaus for a helpful discussion of this issue.

issue of absolute relativism - which for some is not possible – however these are issues that go beyond the scope of this thesis, although I continue to struggle with and to clarify these ideas and debates for myself. Here I merely wish to highlight the interesting and potentially useful outcomes of bringing post-structuralist and social constructionist ideas together with Heidegger's and other versions of phenomenology. I now consider the implications of this research for existential-phenomenological counselling psychology practice.

7.5 Implications for Existential-phenomenological Counselling Psychology practice

In this section I wish to reflect in more detail on the implications of the results for counselling psychology practice. From the detailed results presented in Chapter 6 it can be seen that clients who say they are depressed might be referring to something more akin to the 'blues' (there were two types of the 'blues' identified here, where either overcoming bereavement or where self-reliance and self-awareness were central), it may be an experience where alienation and isolation are significant, or where a lack of feeling is predominant. It may be an experience where feelings of loss and sadness or a loss of meaning predominate. It may also be an experience which more closely resembles the form of depression identified as 'clinical' or 'severe' by the major diagnostic systems. Thus, one important implication for practice is that there is a vital need for gaining a rich and detailed description from the client of exactly what their depression is like, of what is significant or fundamental for them in their experience.

This implication also supports the utility of an existential-phenomenological approach to counselling psychology where the starting point is to gain a detailed description of what the client is bringing and where repeatedly returning to the on-

going description to clarify, refine and alter it can provide a better sense of the 'presenting problem' compared with the practice of identifying and matching diagnostic criteria in order to find the correct nosological category or label. Working with the notion of four interwoven dimensions of existence; the physical, the social, the psychological and the spiritual (van Deurzen and Adams, 2016) is one way in which we can ensure we get as complete a picture as possible of what clients bring and where they are in their difficulties. Clarifying exactly what is happening for one's client within each of the four dimensions enables a fuller and deeper understanding of the client's world, as Yalom (2003: 18) entreats us; 'look out the other's window, try to see the world as your patient sees it'.

A further implication of the findings is the need to properly acknowledge and engage with clients' personal meanings including the questioning, change or absence of personal meaning, (as opposed to primarily aiming to reduce or remove the symptoms of an underlying condition, syndrome or disease). Although such loss or questioning of meaning was most evident with Factor 8, this notion of working with personal meaning, for me, is part and parcel of working with our clients' Being-in-the-world and might encompass the concepts of subjective truth, of shifts in one's sense of belonging, in one's sense of possibilities in the world, which I discussed in the previous section. Indeed, Viktor Frankl has suggested that the 'will to meaning' is a fundamental part of what it is to be human:

> Man [sic] is always reaching out for meaning, always setting out on his search for meaning; in other words what I call the "will to meaning" is even to be regarded as man's primary concern (Frankl, 1979: 29).

To work with meaning is to move away from the pathologisation and objectification that I have argued may result from relying too heavily on diagnosis and medical/psychiatric accounts. To work with meaning is to acknowledge that the client is the foremost expert with regard to their own life, their own thoughts and feelings; with regard to what *matters to them*. As van Deurzen (2009: 2) has suggested:

> … there can be no authority higher than that of our own experience as it is understood in the light of reflection and in comparison with the experience of our fellow humans.

Working with personal meaning also requires us to move beyond our clients' inner world, to look at their choices and the consequences of those choices, at the way they are living their lives, at what they want, at the direction in which they are travelling and/or would like to travel, at their perceived place in the world. Linked to this, Frankl further argues that focusing too exclusively on the therapeutic encounter, on the exchange between the therapist and client, between I and Thou, misses a key dimension of Being; that of the world of meaning beyond the individuals in the encounter, what he calls a 'cosmos of meanings':

> The fact remains that in this view [the encounter as a relationship between I and Thou] something has been left out and it is no more or less than a whole dimension…. a world of "meaning" and this "cosmos" of meanings is what may be aptly called the "logos"… A Psychology deserving of its name has to pay tribute to both halves of that name – the logos as well as the psyche (Frankl, 1979: 65-66).

I take this cosmos of meaning to relate to the wider social and cultural structures, constructions and repertoires that are part and parcel of the world we inhabit and which I have discussed throughout the thesis. Social constructionist and post-structuralist frameworks offer one way to interpret and conceptualise this 'cosmos of meanings', and enable us to understand meaning as exceeding that which is

personal, such that therapeutic intervention should relate not only to personal meaning but also to the ways we all inhabit the wider world of meanings in which we find ourselves, the cosmos of meanings into which we have all been thrown.

Above all, Frankl's placing of meaning-making at the heart of our humanity reminds us of the need to create a facilitative space through our therapeutic work such that personal meaning-making can be revealed and explored without necessarily (or too quickly) bringing in other meanings which may potentially alienate and/or exclude the lived experiences of the client, such as analytic (interpretive) or nosological conceptual frameworks. Furthermore, in this way, Existential-phenomenological counselling psychology practice also requires us to work with a more complex view of personhood and to question those models which tend to categorise and label persons and clients. van Deurzen (2013) describes the approach as follows:

> The existential approach considers human nature to be open-minded, flexible and capable of an enormous range of experience. The person is in a constant process of becoming. I create myself as I exist and have to reinvent myself daily. There is no essential self, as I define my personality and abilities in action and in relation to my environment… Existential thinkers seek to avoid restrictive models that categorize or label people. Instead they look for the universals that can be observed cross-culturally. There is no existential personality theory which divides humanity into types or reduces people to part components. Instead there is a description of the different levels of experience and existence with which people are inevitably confronted. (van Deurzen, 2013: 159)

Following from this, diagnosing depression along the lines of the DSM and the ICD criteria may well impose a framework of understanding that does not fully or meaningfully capture or represent what the client is feeling and thinking. As I argued earlier in the thesis, the reification of depression into a concrete 'thing', into a

diagnostic label, a condition, a syndrome or disease, may pathologise and/or objectify clients through a distortion or negation of their embodied lived experience. Even where such a diagnosis is useful, in that for example medication might be prescribed which the client finds helpful and which reduces the clients immediate risk of suicide, in the longer term a narrower nosological account may well hinder a fuller understating of the client's problems and lead to a less meaningful, trusting and effective relationship or alliance between counselling psychologist and client. If, as human beings, we are always in a state of becoming, our models and understandings as counselling psychologists need to be much more open and flexible, more able to deal with movement, development and change.

It can be seen from the results that the received 'clinical' account of depression broadly captures only one of the various experiences uncovered in this study. Here – as previously - I wish to argue against adopting such a fixed, narrow 'clinical' version of depression in counselling psychology practice. I fear that if we become too enamoured with the claimed authority and scientific credentials of Clinical Psychology and seek to emulate that practice, the DSM/ICD diagnostic criteria could become increasingly incorporated into counselling psychology practice. While the received diagnostic criteria may be useful in identifying some of those clients at high risk of suicide, this study shows that the lived experience of depression is so much more than this narrow conceptualisation. Furthermore, if one agrees with Vicky Rippere (1994) that depression may be something most clients come to therapy with, this call to acknowledge the wide range of experience that can be referred to by the term depression becomes even more important for a counselling psychology practice that fully recognises the variety and complexity of what clients bring to therapy, of what it is to be depressed.

The findings of this study also indicate that there is more to the experience of depression than the abnormal/clinical psychology distinction between 'clinical' and 'non-clinical' depression. Rather, other distinctions or understandings which are more open and cognisant of the client's life-world appear to be required in order to more fully capture the complexity and variety of the experiences found here. One possibly useful distinction might be between 'existential' and 'everyday' depression; where existential depression is seen as a result of a shift in the client's sense of belonging to a shared world, (and the concomitant shifts in their sense of having access to possibilities in the world and of feeling connected to others), and everyday depression seen as a product of having certain kinds of depressive feelings. Rather than working with this distinction as two labels or categories, such a (working) differentiation could instead be used to more effectively help identify where the client's depression could be coming from. Factors 2 and 7, which participants described as the 'blues', would seem to be encompassed by this notion of 'everyday' depression, as would Factors 3 and 5. Whereas Factors 1 and 4 seem to resemble existential depression and this may also be the case for Factors 6 and 8 although this appears less clear without further research. In this way, whereas only Factor 1 broadly fulfilled the received diagnostic criteria for 'clinical' depression, here the other factors/experiences found in this study which seem also to be severe could be more readily recognised and treated as such. Likewise, we should not assume that everyday depression will always be less severe or less debilitating, each client needs to be approached as an individual. At the same time distinguishing certain experiences of depression as existential should not become another label or category, rather this conception could help us to better understand the complexity and subjective truth of the client's lived experience.

One important way to identify and clarify something of the nature of the client's depression could be to look for what Ratcliffe has termed 'existential emotions', which he defines as 'feelings that involve alteration of our overall sense of belonging to a world, rather than something more localized' (Ratliffe, 2013a: 4). Thus, for Ratcliffe, these feelings are linked with a change in one's sense of possibilities in the world. It may be that some, or even many, existential-phenomenological counselling psychologists already practice something like this identification of existential emotions, however the results of this study may well help to begin to clarify or exemplify what this way of working might look like. Moreover, working in a way that more fully acknowledges the existential aspects of depression, I argue, goes some way to lessen the individualising, psychologising and pathologising aspects of the abnormal and clinical psychology/nosological account(s) of depression, such that we would instead see depression as possibly tied in with the clients Being-in-the-world-with-others, as part of their relational world as opposed to primarily contained within the individual's self, body or psyche. In this vein, Caplan (1995) has forcefully argued that contemporary mental health treatment too easily fixes people's troubles within them:

> I believe that far too many people who are badly treated because of their race, sex, age, class, sexual orientation, mental or physical condition, physical appearance, and so on end up seeking psychotherapy because they mistakenly believe that their unhappiness stems from something within themselves. Too much contemporary treatment by mental health professionals, including treatment influenced by the DSM, maintains this almost exclusive focus on individual's psyches, as if the major sources of their troubles came from within them. (Caplan, 1995: xxi)

In contrast to this, existential-phenomenological counselling practice (for example, Yalom, 1980; van Deurzen, 2009) would, I suggest, be well placed to both elicit a full, ongoing and deep understanding of the client's lived experience of

depression - through phenomenological techniques – and to work with the client in a way that fully recognises the relational, existential aspects of some (or possibly, to some extent, all) experiences of depression.

It could also be the case that 'existential' depression may not necessarily respond well to antidepressant medication, particularly in the medium to long term. While drugs may well be very useful for some clients in the short and medium term, especially where there is a higher risk of suicide and/or self-harm, conceptualising some forms of depression as existential suggests that counselling psychology and psychotherapeutic interventions could be more effective in the longer term. If it is acknowledged that some experiences of depression involve a shift in one's Being-in-the-world which brings with it a reduction or even a loss of a sense of access to possibilities (and therefore to a future) and a loss of a sense of connection with others and with the world, then it is possible that a meaningful, trusting and caring relationship or alliance with a counsellor or therapist who is able to clarify and more fully recognise what is happening in the client's life-world, may well offer the prospect of reconnecting with another person and possibly, in time, a reconnection with a deeper sense of belonging in a world with possibilities; although this proposition, of course, is something that would need to be explored with further research.

I also wish to argue here that it is important to understand depression as part and parcel of the human condition, not necessarily something that should always be treated and/or ameliorated through intervention. As Solomon (2014) eloquently suggests:

> Life is fraught with sorrows: no matter what we do, we will in the end die; we are, each of us, held in the solitude of an autonomous body; time passes, and what has been will never be again… despite the enthusiastic claims of pharmaceutical science, depression cannot be wiped out so long as we are creatures conscious of our own selves. It

> can at best be contained – and containing is all that current treatments for depression aim to do. (Solomon, 2014: 16)

Other commentators have questioned the widespread use of anti-depressants in our contemporary culture and have linked the increase in prescriptions for such drugs to wider structures and processes in Western society and culture. For example, the individualisation which is part and parcel of the abnormal and clinical psychology/nosological version(s) of depression may well be ultimately bound up with particular aspects of Western consumerist economic systems and ideologies. Leader (2009) has argued that anti-depressant medication itself can also be seen as reflecting elements of those ideologies:

> Although anti-depressant drugs are prescribed to millions of people in the Western world, with figures rising steadily in other countries, it seems to have occurred to no one purveying a medical cure for depression that the remedy may function as a mirror for the malady. The solitary pill [in a foil strip] sends back a cruel message to whoever opens the packet. This bleak image of separated units conveys the negative side of modern individualism, where each of us is taken to be an isolated agent, cut off from others and driven by competition for goods and services in the market-place rather than by community and shared effort. (Leader, 2009: 1-2)

Matt Haig (2016) has also argued that medicating for depression and other mental health problems is linked to our contemporary reliance on consumption and so called 'normality':

> Medication is an incredibly attractive concept. Not just for the person with depression, or the person running a pharmaceutical firm, but for society as a whole. It underlines the idea that we have hammered into us by the hundred thousand TV ads we have seen that everything can be fixed by consuming things. It fosters a just-shut-up-and-take-the-pill approach, and creates an 'us' and 'them' divide, where everyone can relax and feel 'unreason' – to borrow Michel Foucault's favourite word – is being safely neutered in a society which demands we be normal even if it drives us insane. (Haig, 2016: 30)

For me, while I very much agree with Leader's and Haig's accounts I also wish to acknowledge that for some people antidepressant medication can be immensely helpful and sometimes life-saving. Indeed, Leader (op cit) describes his own experience of medication thus:

> I feel sometimes as though I am swallowing my own funeral twice a day, since without these pills, I'd be long gone. I go to see my therapist once a week when I'm at home. I am sometimes bored by our sessions and sometimes interested in an entirely dissociative way and sometimes have a feeling of epiphany… by themselves pills are a weak poison, love a blunt knife, insight a rope that snaps under too much strain. With the lot of them, if you are lucky, you can save the tree [oneself] from the vine [depression] (Solomon, 2014: 30).

There are no easy remedies for depression. Anti-depressant medication, with its individualising, normalising, consumerist ideological roots, can only ever serve to (temporarily) contain the difficult feelings while the help provided by counselling psychology and other psychotherapeutic interventions will always have its limits. However, this study suggests that a better understanding of the lived experience of depression, including the relational, existential elements of the experience along with the crucial requirement to actively discover the client's subjective truth, as opposed to fitting the client into a narrow, pre-existing diagnostic category or categories, could begin to enable a better understanding of how we can work effectively with clients who are depressed.

Vicky Rippere (1981) who - as I stated at the beginning of this thesis - was an early advocate of researching 'lay' or everyday understandings of depression, reminds us that conceptualising depression as an illness is a relatively recent practice. Moreover, since the 16th Century depression or melancholia has been seen in terms of a lack of wisdom in living, something that corresponds with themes in existential-phenomenological counselling and psychotherapeutic practice, for

example Emmy van Deurzen's notion of the therapist as 'an ally with a modicum of wisdom' (van Deurzen, 2002: 166). Here Rippere lists the various cures for depression that can be traced since the 16th Century:

> The basic notion of circumspect, temperate living, based on knowledge of one's own individual and constitutional susceptibilities, the focus on enhancing efficient biological functioning through attention to diet, sleep and exercise, the strategy of deliberately avoiding known physiological and psychological precipitants, the notion of the individual as a member of a supportive social network, the practice of systematically preparing to face adversity, and, finally, the concept of personal responsibility and initiative in choosing to live with care. (Rippere, 1980: 53)

Even in our contemporary, technology and consumption driven present, Rippere's compilation of long established ways of coping with depression does not appear to have been surpassed. I will now further develop some of these arguments through a reflection on my own way of working and what counselling psychology as a discipline and a practice means to me.

7.6 What is Counselling Psychology for me?

I was drawn to Counselling Psychology training precisely because it, on the whole, is so different from Clinical psychology. The way in which Counselling Psychology aims to incorporate elements of mainstream psychology, in particular through a focus on creating an evidence base, while at the same time staying firmly within a humanist/phenomenological philosophy and value-base, for me opens up a range of new and exciting possibilities. One of these possibilities is to adopt a sophisticated critical and questioning stance towards the dominant medical/clinical models of psychiatry and abnormal psychology which place nosology at the heart of practice, and much of the work found in Critical Psychology could be an important resource here. As I earlier described, I have had a long standing interest and commitment to

questioning and critiquing those elements of psychology which are, or could be, tied up with oppressive and or pathologising theories and practices. The profession of Counselling Psychology, for me, offers a space where we can acknowledge the practical utility of some of the abnormal psychology/diagnostic accounts of depression and other mental health disturbances without falling into the trap of objectifying, distorting the lived experience of, or potentially dehumanising, our clients.

The tensions and contradictions I described in Chapter 3 between what have been termed 'being-in-relation' and 'technical expertise' (Strawbridge and Woolfe, 2003: 5) could be seen as strengths and possibilities for real creativity rather than solely difficulties and challenges. This professional space, which might be described as a space *in between* technical expertise and being-in-relation, is one that I think is incredibly valuable, opening up as it does the possibility of taking a more critical and questioning stance towards, while at the same time not dismissing the value of, (social) science approaches and evidence-based practice. Indeed, living and inhabiting these tensions and possible contradictions, seems far more interesting to me compared with upholding the established (establishment) discourses and practices of clinical and abnormal psychology with their overly narrow conceptualisation of science, psychology, mental health and the person as an 'individual'.

For me, the existential-phenomenological approach to counselling psychology is one that fits very well with my own critical and questioning stance along with my anti-pathologising and client-led way of working. Indeed, having come to the end of my training I see just how crucial this perspective is to my own practice and my sense of identity as a counselling psychologist. The tensions and possible

contradictions in the profession described in Chapter 3, to a large extent reflect many of the critiques and developments in social and other aspects of psychology I described in Chapter 2. Social constructionism developed early on in response to a growing questioning of the utility and relevance of natural science models as an appropriate and/or desirable foundation for psychology. The critiques of individualisation, psychologisation and of the widespread methodolatry (in relation to natural science) in psychology that led to the social constructionist movement in the first place continue to resonate deeply with my own identity and beliefs as a psychologist. To a great extent many of these issues and difficulties remain true of psychology now and existential-phenomenology can respond to them in ways that are positive and constructive and which can usefully inform counselling psychology practice and intervention.

The more complex and relational understanding of the person at the heart of existential-phenomenological counselling psychology practice is, for me, one that goes a long way to addressing many of the concerns embodied in social constructionist perspectives and critiques. In conceptualising the person as always in relation, as inhabiting a complex life-world in which history and temporality play crucial roles, existential-phenomenology enables counselling psychologists to work with a very different model of the 'person'; of our clients and their lived worlds. Here the person is not assumed to have essential qualities but is rather seen as always becoming, always creating and recreating themselves within the relational world that they inhabit. Such a model of the person supports a valuable and much needed focus on the client's lived experience, their relational world and above all the value of their freedom and choice. With respect to working with depression, as I have already highlighted, existential-phenomenological counselling practice may offer a place in

which to understand depression as related to one's sense of being-in-the-world-with-others, one's sense of possibilities and of a future in that relational world.

Practicing phenomenologically means striving to *be with* one's client in *their* world, so that it becomes possible, in a deep and respectful way, to acknowledge where the client is without necessarily having to fix them or their situation, or to offer solutions or 'homework'. In my experience achieving something of this 'meeting' – as Martin Buber called it – can be immensely therapeutic for clients. It can be therapeutic for clients to have somebody who really understands just where they are, who can be with them in that very place, and this is especially true for clients who are depressed where such a 'meeting' is something that for many can be very difficult and sometimes impossible to find with friends and family. Importantly, at the same time, given the openness of the existential-phenomenological approach and its focus on freedom and choice, this way of working does not preclude using a range of techniques drawn from cognitive and other approaches where they fit the client's needs. Although for me, 'being-in-relation' continues to form the bedrock of my own practice.

As I have already said, the work of Michel Foucault has had a profound impact on my professional work and my understanding of myself and the world around me. It can be argued that Foucault was a political activist, that drawing on Nietzsche he saw philosophy as action, as always political and in many ways this is what drew me to his work in the first place. For me counselling psychology practice *is* political, it is one means through which we can question and resist certain sedimented discourses which may operate in oppressive and divisive ways. In this sense, for me listening is not only a psychological, therapeutic process but also a political one, meaning one that relates not only to technique and process but also,

and possibly more profoundly, to the notion of intervention in the world for political reasons, to create positive change; to the notion of phenomenological listening itself as a political response to objectification, dehumanisation and pathologisation.

My own identity as an existential-phenomenological counselling psychologist is very much tied up with my own development as an academic who has long been drawn to alternative modes of theorising and practicing in psychology which strive not to reinforce and reproduce the status quo, not to recapitulate the existing power relations of the discipline and its clinical practices. I feel that the existential-phenomenological approach and the work of Heidegger in particular, offers me a way of working where I can be true to my own thinking and my own ethics which are firmly rooted not only in humanism but also in asking profound questions about the way the world is constructed, how those constructions came about and, where necessary, how they might be changed.

Finally, I believe that as existential-phenomenological counselling psychologists we have a key role to play in resisting a narrow, clinical, bio-medical reduction of the complex, multifaceted lived experience of depression (and other experiences of psychological health issues) and in promoting broader, more relational and existential accounts of depression which can encompass much more of the variety and diversity of what it is to feel and to be depressed.

7.7 Strengths and limitations of the study; possibilities for further research

Q-methodology is a robust technique where, in comparison with other factor analytic/statistical techniques, for example a survey or psychometric scale, participants are more actively involved in creating the data. This approach is very well suited for uncovering shared subjective structures, thoughts, feelings, beliefs

and opinions; in this case I used the technique as a phenomenological method to elicit shared experiences of depression. The use of Q-methodology in this study enabled a detailed snapshot of shared experiences to be taken, however this approach does not produce the kind of very detailed accounts and experiences that can be gained from case study and interview research. Rather, the aim of this work is '…to enable the person to represent his or her vantage point for purposes of holding it constant for inspection and comparison' (Brown, 1997: 2). Thus, the approach to phenomenology adopted in this study enables a broad brush view of different ways of experiencing a particular phenomenon but where there is enough detail for meaningful comparisons between the different experiences.

The sample of statements (Q-set) in this study differentiated very well between participants' diverse experiences. There was only one consensus statement in the study which indicates that the other 57 statements reflected the concourse comprehensively enough to enable participants to distinguish their own particular experience of depression - as evidenced in the 8 interpretable factors found in the study.

Q-methodology does not require a representative person sample as would often be the case with statistical research, rather it requires sampling for diversity so that as many different experiences as possible can be collected and included in the study. Likewise, Q-method does not require very large person samples and usually a range of 40-50 (up to a maximum of 60) is prescribed where numbers higher than this do not normally add more information to the data set. Here I aimed for the mid-point of this range, 50, and achieved a sample of 46. The person sample in this study has some limitations given that is was gained through purposive and snowball sampling methods. The initial phase of sampling consisted of myself contacting

friends and colleagues who then forwarded the research information (through a Facebook page with a link to the Q-sort) and while this gained a reasonably diverse sample there is a skew towards middle age and above, and a skew towards White British participants. This does not invalidate the results – which can be seen as exemplifying some of the possible ways in which persons can experience depression - but rather there needs to be caution in overgeneralising the results; further work would be needed to ascertain the extent to which the experiences found here are also found in wider/other populations.

Such further work could involve repeating the Q-study with a larger and/or more diverse sample, and with different specific samples, for example with individuals who have been diagnosed with depression, or with persons who have never been diagnosed. Additionally, one could use all female or all male samples in order to refine the results of this study along lines of gender and it would also be possible to use Q-method as a means to elicit case-study data, where several Q-sets are given either to one person or to a very small 'case' sample. For me, the most important follow-up research would involve trying to ascertain if the experiences found here are found in other groups, other samples, and whether there are other different, interpretable factors/experiences yet to be identified.

A further limitation to this study relates to its theoretical and conceptual frameworks. As I was reading and researching for this study I came to see the complexity and challenge of bringing together social constructionism, post-structuralism and existential-phenomenology for a thesis of this type. These conceptual frameworks and philosophical traditions have a complex, intertwined history and this complexity became ever more evident as the thesis progressed. Foucault and many other post-structuralists took phenomenology as a key starting

point in their attempts to move beyond foundational frameworks and find other ways to understand the relationships between experience and social and cultural structures and processes. Although I have done my best to set out the lines of some of these conceptual borders and boundaries, a full explication of the philosophical journey from phenomenology to post-structuralism and of the differences between Foucault's and Heidegger's work is beyond the scope of this thesis. That perhaps is best left for another time, another project.

7.8 Final reflection

At the end of this project I wish to give some final personal reflections. This thesis has been concerned with a range of very powerful negative emotions and experiences, including gloom, despair, desolation, despondency, hopelessness and thoughts of death and suicide. While this work has at times affected me deeply, including empathising and sometimes identifying with the experiences that participants shared with me, I have really enjoyed the overall process of research and especially the nature of the contact and connection with participants and especially their reports of their depression that I needed to develop in order to successfully convey their experiences, their personal stories. I have also come to more fully understand that the process of research is just as important as the outcome with regard to personal learning and professional development. This research has taken me back to periods in my own life when I have been depressed, when I have had to deal with the difficulties and struggles that life throws our way. At the same time, I have realised that I have been fortunate and have not – so far – experienced the depths of depression that some participants described in this study. I feel lucky in that respect. I also feel privileged that my participants chose to share

their experiences with me in such a candid and honest way, I am very grateful to them.

At the same time, I have grappled with complex conceptual constructions and configurations, which has both been a real pleasure and a real challenge and in these last few lines I wish to return to the issue of reflexivity. Some years ago I came across a thought-provoking text by Woolgar and Pawluch (1985) who suggested that in social constructionist and other 'definitional' conceptual frameworks, authors problematise and question certain aspects of reality while leaving other aspects of reality unquestioned or even taken-for-granted, in their words:

> Viewed as a practical accomplishment, both theoretical statements and empirical case studies manipulate a boundary, making certain phenomena problematic while leaving others unproblematic. We call the main strategy for managing this boundary ontological gerrymandering. (Woolgar and Pawluch, 1985: 214)

For me this concept of 'ontological gerrymandering' beautifully captures the complexity and difficulty of writing and thinking from a social constructionist perspective. Which parts of reality, of the social, material and experiential world, do we choose to question, which parts do we choose to leave alone, to hold true or even 'sacred'? In this thesis I have told an ultimately personal story, a 'fiction' – although one which I have endeavoured to fully ground in the data - in which the value and utility of the diversity of experiences (and the phenomenology) of depression has been upheld, has been taken as a valid and meaningful starting point both for research and for counselling psychology practice. I have questioned the narrow and potentially pathologising version(s) of depression found in clinical and abnormal psychology, I have represented a type of (primarily Heideggerian) existential understanding as one which more accurately and meaningfully represents

the nature and significance of some experiences of depression. Ontological gerrymandering is, for me, an unavoidable aspect of this way of working; thus rather than judging research on its truth value, constructionism asks us to judge along other lines: usefulness, practical consequences and coherence for example.

Above all for me, my writing is both personal and political, reflecting my own agenda, beliefs, motives, feelings and past and present experience. In this study I have emphasised the crucial role of the client's personal, subjective truth for counselling psychology practice, however the researcher's subjective truth must also be seen as central to the research that we produce as professional psychotherapists and counselling psychologists, and be valued as such.

I hope that I have done justice to the richness and diversity of experiences found in this study and made some contribution towards questioning both the pathologising stance and narrow conceptualisation of depression found in medicine/clinical/abnormal psychology and the established mental health diagnostic systems along with the ever burgeoning reliance on medication as a remedy for something that is often fundamentally relational and existential in nature.

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Appendices

Appendix 1

Briefing, Debriefing, consent and participant details form

Information about the following research project:

Exploring the Phenomenology of Clinical and Non-Clinical Depression: A Q-Methodological Study.

Researcher: Dr. Ian Hodges (ian@ianhodgestherapy.co.uk)

NSPC Ltd
258 Belsize Road
London NW6 4BT

Middlesex University
The Burroughs
London NW4 4BT

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?

Most of us experience some kind of depression at some point in our lives. For some people their depression may become difficult to cope with and may adversely affect their day to day lives and relationships including their ability to work. The purpose of my study is to explore and document in detail the different ways that persons experience depression and enduring sad mood. By focusing on the actual day to day experiences of depression as it is lived by many of us, it is hoped that a rich and detailed picture of the variety of different experiences can be built up. My study is designed so that a comparison can be made between participants' own experiences and the models and theories that professionals use in trying to help people whose depression becomes severe and long lasting. Counsellors and psychotherapists might be able to use the findings from the study to improve the help they give to depressed clients.

What will happen to me if I take part?

You will be asked to complete a few basic details about yourself which will be fully confidential.

You will then be asked to take part in a focus group which will involve discussing your experiences of depression in a group with other participants. The focus group will last up to 60 minutes. If you are able to take part you will be contacted to arrange a time for the focus group to take place. The focus group will take place at the University of Westminster (Regent St.). The discussion will be fully confidential and we will ask all members of the focus group to abide by this. The discussion will be transcribed and the transcript will be used to inform a further study. Any personal information or any comments which may identify any participant will be removed. A full copy of the transcript can be provided if you wish.

What will you do with the information that I provide?

All of the information that you provide me with will be identified only with a project code and stored either on an encrypted USB stick or in a locked filing cabinet. I will keep the key that links your details

with the project code in a locked filing cabinet. The focus groups will be recorded using a digital recorder and I will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. The focus groups may be transcribed by another person. I will not use your real name in the focus group transcript and the person transcribing the discussion will not know who you are.

The information will be kept at least for at least 6 months, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

Data will be stored according to the Data Protection Act and the Freedom of Information Act.

What are the possible disadvantages of taking part?

It is not the intention of the research to upset participants but talking about personal experiences of depression may sometimes be upsetting or distressing. If you no longer wish to continue to participate you will be able to leave the project at any time.

Although this is very unlikely, should you tell me something that I am required by law to pass on to a third person, I will have to do so. Otherwise whatever you tell me will be fully confidential.

What are the possible benefits of taking part?

Sharing one's own experiences with others can be a positive and valuable experience. By taking part in this study you are also making a contribution to advancing our understanding of depression and the ways different people experience it and hopefully contributing to better services and support for people in need.

6. Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign a brief consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason.

7. Who is organising and funding the research?

This research is not funded.

8. Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study.

Thank you for reading this information sheet. If you have any further questions, you can contact me at:

Dr Ian Hodges
ian@ianhodgestherapy.co.uk

Middlesex University School of Health and Social Sciences

New School of Psychotherapy and Counselling

Psychology Department

Written Informed Consent

Title of study: Exploring the Phenomenology of Clinical and Non-Clinical Depression: A Q-Methodological Study.

Researcher: Dr Ian Hodges

Supervisor*:* Dr Georg Nicolaus

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

_____ _____

Print name Sign Name

date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

PARTICIPANT DETAILS FORM (Focus groups only)

Name (first name only) _____

Please complete the following biographical details:

☐ Male

☐ Female

Age: _____

City/town/place of residence _____

Occupation: _____

How would you describe your ethnic origin? _____

Please delete as appropriate:

Have you ever been treated for depression or a related condition?

Yes/No

Have you ever taken prescribed medication for depression or a related condition?

Yes/No

Debrief Information Sheet for research project:

Exploring the Phenomenology of Clinical and Non-Clinical Depression: A Q-Methodological Study.

Carried out by Ian Hodges as a requirement for the DCPsych in Existential Counselling and Psychotherapy from NSPC and Middlesex University.

NSPC Ltd.
258 Belsize Road
London
NW6 4BT

Middlesex University
The Burroughs
London
NW4 4BT

Thank you again for participating in this research. Your contribution is greatly valued. In addition to the debriefing you have been given in person by the researcher this sheet gives you some more information about organisations and websites which you might be interested in following up. If you have any more questions, comments or concerns please feel free to contact the researcher using the following email address:

ian@ianhodgestherapy.co.uk

Please also use this address to request further information about the results of this study as discussed with the researcher.

The study

The purpose if this study was to explore and document the ways that persons experience depression and enduring sad mood. In particular, there was a focus on uncovering the different kinds of experience that might be understood as 'depression' and fully appreciating the varied nature of those different experiences. In this way persons' lived experiences of depression can be compared to the theories and models that professionals use, for example Clinical and Counselling Psychologists, in order to further our understanding of this condition and therefore to provide better treatments and support for those in need.

Further Information:

The following organisations and charities provide useful information and services with regard to depression and related conditions:

The National Health Service provides useful information online here:

http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx

The British Psychological Society is also a useful source of information about Psychology and what Psychologists do:

www.bps.org.uk

The Depression Alliance provides excellent information and various kinds of support:

http://www.depressionalliance.org/

The charity SANE also provides excellent information and various services:

http://www.sane.org.uk/

General advice and information about mental health and depression can be found at the charity MIND here:

http://www.mind.org.uk/

If you are interested in finding a Psychologist, the British Psychological Society provides an online page to search for Chartered Psychologists in the UK:

http://www.bps.org.uk/bpslegacy/dcp

If you are interested in finding an existentialist counsellor you may find the following webpage useful:

http://www.existentialanalysis.org.uk/find-a-therapist/

Thank you for reading this information sheet. If you have any further questions, you can contact me at:

Dr Ian Hodges
ian@ianhodgestherapy.co.uk

Appendix 2

Focus group protocol and sample pictures (stimuli)

Focus group protocol Ian Hodges

Focus group, experiences of depression.

Start:

1) Welcome & thank everyone for coming
2) Ask for consent forms to be signed
3) Distribute bio questionnaire
4) Ground rules:

   I would like everyone to participate

   There are no right or wrong answers, everyone's experience is important

   I want to hear the full range of experiences – this is crucial to the research

   Remind participants that it is up to them how much they share with the group. This will depend on what participants are comfortable with.

   It's important that what we say here in this room should stay in this room

   I'll be recording the group. No-one will be identified on the transcript or in the research

Warm up

1) Ask participants to introduce themselves (name labels if appropriate)

   Back up:

   Tell us about something you saw or noticed on the way here.

   OR

   Favourite food? Favourite film/book etc.? Why?

2) Introduce topic

I am interested in the ways in which people experience depression and enduring, long term sadness. These terms only refer to a general area of experience, it is how each of you have experienced these that is important, you may apply different labels - which is also of interest. This stage of the research is exploratory, laying the ground for a further study with more participants using a different method, a sorting task.

Stage 1: Engagement

1) Exercise: Choose an image or images that represent a sad, depressed feeling or feelings you've experienced or are experiencing. Facilitate each member discussing this:

   Why this picture?

Does it evoke a particular feeling/memory?

What was it like?

Stage 2: Exploratory questions (in conjunction with stage 1)

Key questions:

What did you feel?

What kind of thoughts?

How did episode begin/end?

How long did it last?

One episode or more?

What about:

Loss of interest or pleasure?

Sleep?

Appetite? weight loss/gain?

Energy levels?

Stress?

Concentration?

Self-care?

Drinking/smoking?

Medication?

Work?

Triggers?

Effect on relationships/partner//family/children?

Effect on others/did others notice?

Thoughts of suicide?

Continuation questions:

Has anyone else had the same or a different experience?

Does anyone feel differently about this?

Stage 3: Exit question

1) Is there anything else you would like to add? Something important we haven't discussed?

Closing down:

1) What's it been like this evening? How are you feeling now (go round group so each person is able to share this).
2) Tell us about something positive you can take from this group.

Finally:

1) Hand out final information sheet
2) Reaffirm confidentiality and thank participants

Example images used for focus group stimuli (all printed as A4)


Help!

Appendix 3

Table of themes/issues for preliminary study

Table A1: Table of interrelated themes and key issues (preliminary study)

Overarching theme: Feeling depressed/depressed feelings		
Related Theme	*Related Theme*	*Related Theme*
Living with depression	Making sense of depression	Dealing with others' reactions
Key issues	*Key issues*	*Key issues*
Cycle of depression/triggers	Ordinary sadness vs 'real' depression	Others not understanding/not taking the depression seriously
Ways of coping/getting help	Framing depression/looking for causes	Difference and isolation
Wanting to stay 'in the hole'/resisting help	Outlook on life	Not wanting to burden others

Appendix 4

Q-set (statements)

Table A2: Table showing all statements used in Q-study (DSM statements in bold)

Number	Statement (DSM statements in BOLD)
1	I experience a deep feeling of being alone and cut off from other people
2	Although on the outside I seem OK, on the inside I'm going throug
3	I feel as though others have no idea how truly awful the experience is
4	I experience all sorts of aches and pains around my body
5	I feel tense and anxious most of the time
6	It feels as though the normal rhythm of my body clock is seriously disrupted
7	**I notice that most of the time my bodily movements have slowed right down**
8	**I experience fatigue or loss of energy nearly every day**
9	I have little or no interest in sex
10	I intentionally injure my body, for example cutting or burning my skin
11	**I feel sad and/or empty much or all of the day**
12	I find myself dwelling on the things that I've lost
13	**My interest and/or pleasure in almost all of my activities is very diminished**
14	**Most of the time my ability to concentrate and make decisions is diminished**
15	I find myself becoming more aggressive
16	I am sometimes totally devoid of feeling
17	I feel as though everything is hopeless
18	However bad it gets I know that I have to survive and get through it
19	**I experience recurrent thoughts of death and of taking my own life**
20	I find that sleep is my only escape
21	**I experience a decrease in my appetite nearly every day**
22	**I find myself sleeping too much nearly every day**
23	**I feel worthless and/or excessively guilty nearly every day**
24	I feel as though other people think I'm just being selfish
25	I get this internal voice which is negative and very critical of myself
26	I know that I'm not helpless, I can get myself out of it
27	No matter how hard I try I just can't take control of my thoughts and my feelings
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window
29	I find myself taking many more risks than I would normally
30	Time seems to slow down for me
31	I find it hard to imagine a different or better future
32	I have alternating periods when I'm down and when I'm up
33	I feel as though something, like a chemical, has been released in my brain
34	My feelings could be best described as the 'blues'
35	I know that it's the price I have to pay for creativity
36	I am aware that it is a result of a physical illness
37	I am aware that I need to get some sunshine

38	Although it's difficult right now, I know it's part of the cycle of life
39	I find myself struggling with the question 'how do you live this life?'
40	I feel that I need answers to why this is happening to me
41	I find myself wondering 'what's the point of my life?'
42	My life and the world seem meaningless
43	Rather than burden others, I try to fix my problems for myself
44	Professional help is the last thing I need
45	Anti-depressant medication really helps me
46	I cling to the belief that there is a God who cares
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself
48	I feel unsafe in my house, at work, everywhere
49	I fear being judged if I tell others about it
50	I'm not able to trust my senses, memory or my judgement
51	I feel ashamed of my depression
52	I worry about the effect that my depression will have on my family and close relationships
53	I avoid seeing other people because I know I'll make them feel bad too
54	I feel guilty that I can't just pull myself together
55	I feel more anxious because I don't know what's causing it
56	I find it hard to distinguish what's real and what I've imagined
57	I find myself becoming secretive and paranoid
58	I experience bizarre thoughts and delusions

Appendix 5

Results tables for Q-study

Table A3: Rotated Factor Matrix with an X Indicating a Defining Sort (also in bold)

Q-sort	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8
1	0.1176	0.2729	0.0139	0.5340	-0.0403	0.1578	0.3620	0.2438
2	0.2861	0.0967	0.2235	0.0743	0.2175	-0.0754	0.0173	**0.5996X**
3	-0.0531	-0.0825	-0.1080	0.1262	0.3801	0.2592	0.3562	0.6091
4	0.2222	-0.0411	-0.0225	0.3390	-0.0790	**0.6316X**	-0.1563	0.1017
5	0.0470	0.2643	-0.3039	-0.0660	0.0574	0.0338	0.4785	0.4828
6	0.2233	0.4842	0.3076	0.2117	0.0837	0.1574	-0.0805	0.1611
7	0.4139	-0.0344	0.1190	0.0292	0.0690	0.4762	0.4863	0.2310
8	0.4403	0.1335	0.1999	-0.1134	0.4174	0.2998	0.0291	0.1282
9	0.4349	-0.0230	0.0756	0.4013	-0.3233	0.4145	-0.1864	-0.0219
10	-0.1157	0.1432	0.1921	-0.0019	0.1836	-0.0894	**0.7606X**	-0.0322
11	0.2196	0.2531	0.1252	**0.6837X**	0.2308	0.1350	-0.0648	0.2968
12	0.1926	-0.0590	0.1875	0.2782	0.0897	**0.5759X**	-0.1921	0.2043
13	0.4871	-0.0933	0.0276	0.1908	0.4412	0.2752	0.1743	0.1335
14	**0.6911X**	0.1754	-0.1334	0.1025	0.0606	0.2302	0.0168	0.1752
15	0.5752	0.1026	-0.0259	0.0950	0.0944	0.5229	0.0447	0.2624
16	-0.1653	**0.7390X**	0.0510	-0.0219	0.2957	0.2459	0.0483	0.0560
17	0.4708	0.0826	0.0951	-0.0005	0.4622	0.1109	0.0216	0.1927
18	0.0759	0.0435	**0.7010X**	0.0781	0.2646	-0.1066	0.2431	0.0998
19	0.0882	-0.1659	-0.2515	**0.6147X**	0.1121	0.0838	-0.0037	0.0650
20	-0.0632	0.1201	0.3740	0.1131	-0.0790	-0.0747	**0.5565X**	0.3370
21	0.1526	-0.0411	0.1801	0.4433	0.0830	0.2208	0.3559	0.3975
22	**0.7230X**	-0.0700	0.0931	0.0177	0.2013	0.2349	0.1523	0.1862
23	-0.0520	0.2813	0.2651	0.5265	0.3191	0.0870	0.3716	0.1183
24	0.3035	0.4734	0.2610	0.4626	0.1474	0.1368	0.0975	0.0316
25	**0.6113X**	0.1286	-0.0323	0.2579	0.0765	-0.0164	-0.2483	0.0522
26	0.0389	0.1111	0.0934	0.1608	**0.6036X**	0.1079	-0.0107	0.3032
27	0.0740	0.1226	0.0272	0.1187	0.2248	0.0711	0.0835	**0.7569X**
28	0.2968	-0.0593	0.0768	0.3859	0.0940	0.3025	0.0110	0.4793
29	-0.0660	0.1814	0.1313	0.2744	**0.5783X**	0.0381	0.1187	0.2914
30	0.0152	0.1354	0.0105	-0.0830	0.1471	**0.7461X**	0.0120	-0.0318
31	-0.0952	0.4063	0.1368	0.4679	0.2097	0.1071	0.3732	0.1194
32	0.1502	0.1281	**0.5653X**	-0.0257	0.0697	0.2005	0.0925	0.2622
33	0.2743	0.0424	-0.0605	0.1889	0.0694	-0.1750	**0.5219X**	0.1233
34	0.0976	**0.5993X**	0.1423	0.1596	-0.0909	-0.2010	-0.0329	0.3831
35	0.3245	0.2462	0.2707	0.2631	-0.0033	0.2818	0.1423	0.5166
36	0.4787	0.1082	0.0003	0.2610	0.0013	0.5574	0.1395	-0.0745
37	0.3805	0.2880	0.0280	-0.0357	0.0445	0.3907	0.3642	0.4860
38	0.0283	**0.7209X**	-0.0922	-0.0947	-0.0275	-0.0990	0.3314	-0.0056
39	0.0882	0.3216	-0.4295	0.2793	0.2143	-0.0523	0.2199	0.0487
40	0.1014	0.2963	0.4739	0.0656	0.3537	0.0838	0.0269	-0.2469
41	0.4876	0.0854	0.0784	0.4955	0.1553	0.0467	0.2683	-0.1464
42	0.2435	0.0183	0.0553	0.1129	**0.6072X**	-0.0040	0.1171	0.0258
43	0.3886	0.3574	0.3720	0.1516	0.2157	0.1400	0.2445	0.0432
44	**0.6700X**	-0.1394	0.2426	0.0727	-0.0497	0.0779	0.0084	0.0490
45	0.3519	0.0167	0.0807	0.1840	0.1813	0.5680	0.0176	0.4429
46	0.3077	-0.0992	0.0122	0.4664	0.3122	0.4620	-0.1633	0.0711
% Expl. variance	11	7	5	8	6	9	7	8

Table A4: Factor scores for Factor 1

Factor 1: 'Clinical'/suicidal depression			
Explained variance		11%	
Participants loading significantly on factor		4	
Number	**Statement**	**Grid**	**Z-score**
23	**I feel worthless and/or excessively guilty nearly every day**	5	1.815
11	**I feel sad and/or empty much or all of the day**	5	1.814
19	**I experience recurrent thoughts of death and of taking my own life**	5	1.757
8	**I experience fatigue or loss of energy nearly every day**	4	1.739
25	I get this internal voice which is negative and very critical of myself	4	1.617
17	I feel as though everything is hopeless	4	1.458
39	I find myself struggling with the question 'how do you live this life?'	4	1.425
31	I find it hard to imagine a different or better future	3	1.333
16	I am sometimes totally devoid of feeling	3	1.135
52	I worry about the effect that my depression will have on my family and close relationships	3	1.002
13	**My interest and/or pleasure in almost all of my activities is very diminished**	3	0.919
42	My life and the world seem meaningless	3	0.721
14	**Most of the time my ability to concentrate and make decisions is diminished**	2	0.615
51	I feel ashamed of my depression	2	0.607
12	I find myself dwelling on the things that I've lost	2	0.567
54	I feel guilty that I can't just pull myself together	2	0.566
20	I find that sleep is my only escape	2	0.559
1	I experience a deep feeling of being alone and cut off from other people	2	0.525
3	I feel as though others have no idea how truly awful the experience is	1	0.478
2	Although on the outside I seem OK, on the inside I'm going through hell	1	0.478
41	I find myself wondering 'what's the point of my life?'	1	0.477
9	I have little or no interest in sex	1	0.466
27	No matter how hard I try I just can't take control of my thoughts and my feelings	1	0.416
32	I have alternating periods when I'm down and when I'm up down	1	0.378
4	I experience all sorts of aches and pains around my body	1	0.283
5	I feel tense and anxious most of the time	0	0.281
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	0	0.127
22	**I find myself sleeping too much nearly every day**	0	0.030
30	Time seems to slow down for me	0	-0.063
37	I am aware that I need to get some sunshine	0	-0.093
45	Anti-depressant medication really helps me	0	-0.100
49	I fear being judged if I tell others about it	0	-0.125

18	However bad it gets i know that I have to survive and get through it	0	-0.204
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-1	-0.240
38	Although it's difficult right now, I know it's part of the cycle of life	-1	-0.286
26	I know that I'm not helpless, I can get myself out of it	-1	-0.296
50	I'm not able to trust my senses, memory or judgement	-1	-0.373
21	**I experience a decrease in my appetite nearly every day**	-1	-0.396
48	I feel unsafe in my house, at work, everywhere	-1	-0.402
43	Rather than burden others, I try to fix my problems for myself	-1	-0.404
24	I feel as though other people think I'm just being selfish	-2	-0.557
7	**I notice that most of the time my bodily movements have slowed right down**	-2	-0.579
36	I am aware that it is a result of a physical illness	-2	-0.629
53	I avoid seeing other people because I know I'll make them feel bad too	-2	-0.691
33	I feel as though something, like a chemical, has been released in my brain	-2	-0.699
46	I cling to the belief that there is a God who cares	-2	-0.735
15	I find myself becoming more aggressive	-3	-0.806
56	I find it hard to distinguish what's real and what I've imagined	-3	-0.865
40	I feel that I need answers to why this is happening to me	-3	-0.954
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out the window	-3	-1.068
34	My feelings could be best described as the 'blues'	-3	-1.278
44	Professional help is the last thing I need	-4	-1.279
55	I feel more anxious because I don't know what's causing it	-4	-1.392
35	I know that it's the price I have to pay for creativity	-4	-1.565
29	I find myself taking many more risks than I would normally	-4	-1.731
58	I experience bizarre thoughts and delusions	-5	-1.805
10	I intentionally injure my body, for example cutting or burning my skin	-5	-1.951
57	I find myself becoming secretive and paranoid	-5	-2.022

Table A5: Factor scores for Factor 2

Factor 2: The 'blues'/overcoming loss and bereavement			
Explained variance		7%	
Participants loading significantly on factor		3	
Number	**Statement**	**Grid**	**Z-score**
34	My feelings could be best described as the 'blues'	5	2.182
32	I have alternating periods when I'm down and when I'm up	5	1.562
52	I worry about the effect that my depression will have on my family and close relationships	5	1.499
43	Rather than burden others, I try to fix my problems for myself	4	1.489
1	I experience a deep feeling of being alone and cut off from other people	4	1.446
26	I know that I'm not helpless, I can get myself out of it	4	1.409
27	No matter how hard I try I just can't take control of my thoughts and my feelings	4	1.387
55	I feel more anxious because I don't know what's causing it	3	1.220
38	Although it's difficult right now, I know it's part of the cycle of life	3	1.058
18	However bad it gets I know that I have to survive and get through it	3	1.000
4	I experience all sorts of aches and pains around my body	3	0.906
54	I feel guilty that I can't just pull myself together	3	0.892
13	**My interest and/or pleasure in almost all of my activities is very diminished**	2	0.881
2	Although on the outside I seem OK, on the inside I'm going through hell	2	0.847
5	I feel tense and anxious most of the time	2	0.802
23	**I feel worthless and/or excessively guilty nearly every day**	2	0.774
9	I have little or no interest in sex	2	0.759
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	2	0.744
12	I find myself dwelling on the things that I've lost	1	0.721
51	I feel ashamed of my depression	1	0.635
11	**I feel sad and/or empty much or all of the day**	1	0.503
53	I avoid seeing other people because I know I'll make them feel bad too	1	0.461
35	I know that it's the price I have to pay for creativity	1	0.395
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	1	0.365
37	I am aware that I need to get some sunshine	1	0.292
3	I feel as though others have no idea how truly awful the experience is	0	0.104
49	I fear being judged if I tell others about it	0	0.096
8	**I experience fatigue or loss of energy nearly every day**	0	0.081
58	I experience bizarre thoughts and delusions	0	-0.081
15	I find myself becoming more aggressive	0	-0.145
22	**I find myself sleeping too much nearly every day**	0	-0.147
41	I find myself wondering 'what's the point of my life?'	0	-0.162
14	**Most of the time my ability to concentrate and make decisions is diminished**	0	-0.174
44	Professional help is the last thing I need	-1	-0.272

33	I feel as though something, like a chemical, has been released in my brain	-1	-0.299
21	**I experience a decrease in my appetite nearly every day**	-1	-0.344
16	I am sometimes totally devoid of feeling	-1	-0.431
36	I am aware that it is a result of a physical illness	-1	-0.446
20	I find that sleep is my only escape	-1	-0.448
24	I feel as though other people think I'm just being selfish	-1	-0.554
7	**I notice that most of the time my bodily movements have slowed right down**	-2	-0.612
48	I feel unsafe in my house, at work, everywhere	-2	-0.701
46	I cling to the belief that there is a God who cares	-2	-0.745
29	I find myself taking many more risks than I would normally	-2	-0.840
40	I feel that I need answers to why this is happening to me	-2	-0.853
30	Time seems to slow down for me	-2	-0.883
50	I'm not able to trust my senses, memory or my judgement	-3	-0.896
56	I find it hard to distinguish what's real and what I've imagined	-3	-0.898
10	I intentionally injure my body, for example cutting or burning my skin	-3	-1.116
17	I feel as though everything is hopeless	-3	-1.124
39	I find myself struggling with the question 'how do you live this life?'	-3	-1.329
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-4	-1.380
25	I get this internal voice which is negative and very critical of myself	-4	-1.461
45	Anti-depressant medication really helps me	-4	-1.467
57	I find myself becoming secretive and paranoid	-4	-1.503
19	**I experience recurrent thoughts of death and of taking my own life**	-5	-1.527
42	My life and the world seem meaningless	-5	-1.584
31	I find it hard to imagine a different or better future	-5	-2.088

Table A6: Factor scores for Factor 3

Factor 3: Anxious/'non-clinical' depression			
Explained variance		5%	
Participants loading significantly on factor		2	
Number	**Statement**	**Grid**	**Z-score**
5	I feel tense and anxious most of the time	5	1.866
2	Although on the outside I seem OK, on the inside I'm going through hell	5	1.701
3	I feel as though others have no idea how truly awful the experience is	5	1.701
13	**My interest and/or pleasure in almost all of my activities is very diminished**	4	1.648
25	I get this internal voice which is negative and very critical of myself	4	1.592
54	I feel guilty that I can't just pull myself together	4	1.483
9	I have little or no interest in sex	4	1.374
46	I cling to the belief that there is a God who cares	3	1.374
14	**Most of the time my ability to concentrate and make decisions is diminished**	3	1.153
18	However bad it gets I know that I have to survive and get through it	3	1.096
24	I feel as though other people think I'm just being selfish	3	0.988
33	I feel as though something, like a chemical, has been released in my brain	3	0.935
26	I know that I'm not helpless, I can get myself out of it	2	0.931
16	I am sometimes totally devoid of feeling	2	0.879
4	I experience all sorts of aches and pains around my body	2	0.822
43	Rather than burden others, I try to fix my problems for myself	2	0.766
31	I find it hard to imagine a different or better future	2	0.713
11	**I feel sad and/or empty much or all of the day**	2	0.605
41	I find myself wondering 'what's the point of my life?'	1	0.387
17	I feel as though everything is hopeless	1	0.274
37	I am aware that I need to get some sunshine	1	0.274
39	I find myself struggling with the question 'how do you live this life?'	1	0.165
57	I find myself becoming secretive and paranoid	1	0.165
55	I feel more anxious because I don't know what's causing it	1	0.056
49	I fear being judged if I tell others about it	1	0.053
58	I experience bizarre thoughts and delusions	0	0.000
38	Although it's difficult right now, I know it's part of the cycle of life	0	-0.053
12	I find myself dwelling on the things that I've lost	0	-0.056
42	My life and the world seem meaningless	0	-0.109
50	I'm not able to trust my senses, memory or my judgement	0	-0.109
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	0	-0.113
36	I am aware that it is a result of a physical illness	0	-0.165
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	0	-0.165
44	Professional help is the last thing I need	-1	-0.222
15	I find myself becoming more aggressive	-1	-0.222
40	I feel that I need answers to why this is happening to me	-1	-0.327

32	I have alternating periods when I'm down and when I'm up	-1	-0.330
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-1	-0.330
34	My feelings could be best described as the 'blues'	-1	-0.383
52	I worry about the effect that my depression will have on my family and close relationships	-1	-0.436
30	Time seems to slow down for me	-2	-0.439
51	I feel ashamed of my depression	-2	-0.439
53	I avoid seeing other people because I know I'll make them feel bad too	-2	-0.548
27	No matter how hard I try I just can't take control of my thoughts and my feelings	-2	-0.548
1	I experience a deep feeling of being alone and cut off from other people	-2	-0.601
7	**I notice that most of the time my bodily movements have slowed right down**	-2	-0.605
45	Anti-depressant medication really helps me	-3	-0.826
20	I find that sleep is my only escape	-3	-0.988
35	I know that it's the price I have to pay for creativity	-3	-1.044
48	I feel unsafe in my house, at work, everywhere	-3	-1.153
29	I find myself taking many more risks than I would normally	-3	-1.209
8	**I experience fatigue or loss of energy nearly every day**	-4	-1.262
56	I find it hard to distinguish what's real and what I've imagined	-4	-1.371
23	**I feel worthless and/or excessively guilty nearly every day**	-4	-1.483
22	**I find myself sleeping too much nearly every day**	-4	-1.592
19	**I experience recurrent thoughts of death and of taking my own life**	-5	-1.648
21	**I experience a decrease in my appetite nearly every day**	-5	-2.031
10	I intentionally injure my body, for example cutting or burning my skin	-5	-2.197

Table A7: Factor scores for Factor 4

Factor 4: Emotionally devoid/isolated depression			
Explained variance		8%	
Participants loading significantly on factor		2	
Number	**Statement**	**Grid**	**Z-score**
16	I am sometimes totally devoid of feeling	5	2.006
1	I experience a deep feeling of being alone and cut off from other people	5	1.624
23	**I feel worthless and/or excessively guilty nearly every day**	5	1.566
32	I have alternating periods when I'm down and when I'm up	4	1.566
39	I find myself struggling with the question 'how do you live this life?'	4	1.452
11	**I feel sad and/or empty much or all of the day**	4	1.375
25	I get this internal voice which is negative and very critical of myself	4	1.375
5	I feel tense and anxious most of the time	3	1.318
12	I find myself dwelling on the things that I've lost	3	1.241
55	I feel more anxious because I don't know what's causing it	3	1.203
57	I find myself becoming secretive and paranoid	3	1.127
29	I find myself taking many more risks than I would normally	3	1.070
53	I avoid seeing other people because I know I'll make them feel bad too	2	1.012
41	I find myself wondering 'what's the point of my life?'	2	0.955
14	**Most of the time my ability to concentrate and make decisions is diminished**	2	0.879
37	I am aware that I need to get some sunshine	2	0.745
13	**My interest and/or pleasure in almost all of my activities is very diminished**	2	0.688
31	I find it hard to imagine a different or better future	2	0.439
15	I find myself becoming more aggressive	1	0.439
49	I fear being judged if I tell others about it	1	0.268
52	I worry about the effect that my depression will have on my family and close relationships	1	0.248
34	My feelings could be best described as the 'blues'	1	0.191
58	I experience bizarre thoughts and delusions	1	0.191
27	No matter how hard I try I just can't take control of my thoughts and my feelings	1	0.172
42	My life and the world seem meaningless	1	0.134
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	0	0.114
20	I find that sleep is my only escape	0	0.057
17	I feel as though everything is hopeless	0	0.057
6	It feels as though the normal rhythm of my body clock is seriously disrupted	0	0.019
54	I feel guilty that I can't just pull myself together	0	-0.019
8	**I experience fatigue or loss of energy nearly every day**	0	-0.057
21	**I experience a decrease in my appetite nearly every day**	0	-0.172
50	I'm not able to trust my senses, memory or judgement	0	-0.191
3	I feel as though others have no idea how truly awful the experience is	-1	-0.191

18	However bad it gets I know that I have to survive and get through it	-1	-0.248
2	Although on the outside I seem OK, on the inside I'm going through hell	-1	-0.268
40	I feel that I need answers to why this is happening to me	-1	-0.382
26	I know that I'm not helpless, I can get myself out of it	-1	-0.382
44	Professional help is the last thing I need	-1	-0.439
56	I find it hard to distinguish what's real and what I've imagined	-1	-0.497
19	**I experience recurrent thoughts of death and of taking my own life**	-2	-0.630
51	I feel ashamed of my depression	-2	-0.688
30	Time seems to slow down for me	-2	-0.688
33	I feel as though something, like a chemical, has been released in my brain	-2	-0.745
43	Rather than burden others, I try to fix my problems for myself	-2	-0.821
9	I have little or no interest in sex	-2	-0.955
7	**I notice that most of the time my bodily movements have slowed right down**	-3	-0.993
38	Although it's difficult right now, I know it's part of the cycle of life	-3	-1.012
45	Anti-depressant medication really helps me	-3	-1.050
4	I experience all sorts of aches and pains around my body	-3	-1.070
24	I feel as though other people think I'm just being selfish	-3	-1.070
35	I know that it's the price I have to pay for creativity	-4	-1.127
48	I feel unsafe in my house, at work, everywhere	-4	-1.241
22	**I find myself sleeping too much nearly every day**	-4	-1.318
47	Although anti-depressants numb the pain, they make me feel like I’ve lost a part of myself	-4	-1.375
36	I am aware that it is a result of a physical illness	-5	-1.757
10	I intentionally injure my body, for example cutting or burning my skin	-5	-1.948
46	I cling to the belief that there is a God who cares	-5	-2.197

Table A8: Factor scores for Factor 5

Factor 5: Sadness and loss/surviving depression			
Explained variance		6%	
Participants loading significantly on factor		3	
Number	**Statement**	**Grid**	**Z-score**
12	I find myself dwelling on the things that I've lost	5	2.287
18	However bad it gets I know that I have to survive and get through it	5	1.968
11	**I feel sad and/or empty much or all of the day**	5	1.800
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	4	1.522
25	I get this internal voice which is negative and very critical of myself	4	1.474
1	I experience a deep feeling of being alone and cut off from other people	4	1.333
2	Although on the outside I seem OK, on the inside I'm going through hell	4	1.294
53	I avoid seeing other people because I know I'll make them feel bad too	3	1.153
38	Although it's difficult right now, I know it's part of the cycle of life	3	1.149
3	I feel as though others have no idea how truly awful the experience is	3	1.108
54	I feel guilty that I can't just pull myself together	3	1.106
7	**I notice that most of the time my bodily movements have slowed right down**	3	1.009
37	I am aware that I need to get some sunshine	2	0.842
30	Time seems to slow down for me	2	0.680
5	I feel tense and anxious most of the time	2	0.641
43	Rather than burden others, I try to fix my problems for myself	2	0.639
41	I find myself wondering 'what's the point of my life?'	2	0.629
8	**I experience fatigue or loss of energy nearly every day**	2	0.629
31	I find it hard to imagine a different or better future	1	0.371
17	I feel as though everything is hopeless	1	0.352
32	I have alternating periods when I'm down and when I'm up	1	0.321
26	I know that I'm not helpless, I can get myself out of it	1	0.277
58	I experience bizarre thoughts and delusions	1	0.201
14	**Most of the time my ability to concentrate and make decisions is diminished**	1	0.180
13	**My interest and/or pleasure in almost all of my activities is very diminished**	1	0.166
39	I find myself struggling with the question 'how do you live this life?'	0	0.139
52	I worry about the effect that my depression will have on my family and close relationships	0	0.023
29	I find myself taking many more risks than I would normally	0	0.019
40	I feel that I need answers to why this is happening to me	0	-0.008
15	I find myself becoming more aggressive	0	-0.033
55	I feel more anxious because I don't know what's causing it	0	-0.043
48	I feel unsafe in my house, at work, everywhere	0	-0.141
42	My life and the world seem meaningless	0	-0.293

27	No matter how hard I try I just can't take control of my thoughts and my feelings	-1	-0.307
16	I am sometimes totally devoid of feeling	-1	-0.352
24	I feel as though other people think I'm just being selfish	-1	-0.356
9	I have little or no interest in sex	-1	-0.449
21	**I experience a decrease in my appetite nearly every day**	-1	-0.501
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	-1	-0.508
49	I fear being judged if I tell others about it	-1	-0.508
57	I find myself becoming secretive and paranoid	-2	-0.555
23	**I feel worthless and/or excessively guilty nearly every day**	-2	-0.610
51	I feel ashamed of my depression	-2	-0.622
36	I am aware that it is a result of a physical illness	-2	-0.653
35	I know that it's the price I have to pay for creativity	-2	-0.692
34	My feelings could be best described as the 'blues'	-2	-0.832
22	**I find myself sleeping too much nearly every day**	-3	-0.961
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-3	-0.964
45	Anti-depressant medication really helps me	-3	-0.985
56	I find it hard to distinguish what's real and what I've imagined	-3	-0.987
46	I cling to the belief that there is a God who cares	-3	-1.102
33	I feel as though something, like a chemical, has been released in my brain	-4	-1.141
19	**I experience recurrent thoughts of death and of taking my own life**	-4	-1.169
20	I find that sleep is my only escape	-4	-1.200
50	I'm not able to trust my senses, memory or judgement	-4	-1.444
4	I experience all sorts of aches and pains around my body	-5	-1.472
10	I intentionally injure my body, for example cutting or burning my skin	-5	-2.117
44	Professional help is the last thing I need	-5	-2.304

Table A9: Factor scores for Factor 6

Factor 6: Alienated/helpless depression			
Explained variance		9%	
Participants loading significantly on factor		3	
Number	**Statement**	**Grid**	**Z-score**
2	Although on the outside I seem OK, on the inside I'm going through hell	5	1.987
1	I experience a deep feeling of being alone and cut off from other people	5	1.448
43	Rather than burden others, I try to fix my problems for myself	5	1.421
27	No matter how hard I try I just can't take control of my thoughts and my feelings	4	1.364
41	I find myself wondering 'what's the point of my life?'	4	1.332
11	**I feel sad and/or empty much or all of the day**	4	1.307
3	I feel as though others have no idea how truly awful the experience is	4	1.281
17	I feel as though everything is hopeless	3	1.229
51	I feel ashamed of my depression	3	1.194
53	I avoid seeing other people because I know I'll make them feel bad too	3	0.948
42	My life and the world seem meaningless	3	0.945
14	**Most of the time my ability to concentrate and make decisions is diminished**	3	0.915
5	I feel tense and anxious most of the time	2	0.907
52	I worry about the effect that my depression will have on my family and close relationships	2	0.829
57	I find myself becoming secretive and paranoid	2	0.815
39	I find myself struggling with the question 'how do you live this life?'	2	0.796
10	I intentionally injure my body, for example cutting or burning my skin	2	0.747
20	I find that sleep is my only escape	2	0.657
8	**I experience fatigue or loss of energy nearly every day**	1	0.598
49	I fear being judged if I tell others about it	1	0.593
58	I experience bizarre thoughts and delusions	1	0.569
13	**My interest and/or pleasure in almost all of my activities is very diminished**	1	0.546
48	I feel unsafe in my house, at work, everywhere	1	0.517
24	I feel as though other people think I'm just being selfish	1	0.490
23	**I feel worthless and/or excessively guilty nearly every day**	1	0.376
16	I am sometimes totally devoid of feeling	0	0.357
31	I find it hard to imagine a different or better future	0	0.328
19	**I experience recurrent thoughts of death and of taking my own life**	0	0.305
33	I feel as though something, like a chemical, has been released in my brain	0	0.298
54	I feel guilty that I can't just pull myself together	0	0.140
40	I feel that I need answers to why this is happening to me	0	-0.111
25	I get this internal voice which is negative and very critical of myself	0	-0.128
35	I know that it's the price I have to pay for creativity	0	-0.271

30	Time seems to slow down for me	-1	-0.276
50	I'm not able to trust my senses, memory or my judgement	-1	-0.293
22	**I find myself sleeping too much nearly every day**	-1	-0.295
55	I feel more anxious because I don't know what's causing it	-1	-0.433
56	I find it hard to distinguish what's real and what I've imagined	-1	-0.439
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	-1	-0.603
18	However bad it gets I know that I have to survive and get through it	-1	-0.660
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	-2	-0.780
12	I find myself dwelling on the things that I've lost	-2	-0.787
7	**I notice that most of the time my bodily movements have slowed right down**	-2	-0.839
44	Professional help is the last thing I need	-2	-0.850
32	I have alternating periods when I'm down and when I'm up	-2	-0.926
4	I experience all sorts of aches and pains around my body	-2	-0.974
6	It feels as though the normal rhythm of my body clock is seriously disrupted	-3	-1.056
34	My feelings could be best described as the 'blues'	-3	-1.113
15	I find myself becoming more aggressive	-3	-1.115
9	I have little or no interest in sex	-3	-1.118
37	I am aware that I need to get some sunshine	-3	-1.259
26	I know that I'm not helpless, I can get myself out of it	-4	-1.278
38	Although it's difficult right now, I know it's part of the cycle of life	-4	-1.312
29	I find myself taking many more risks than I would normally	-4	-1.416
21	**I experience a decrease in my appetite nearly every day**	-4	-1.519
36	I am aware that it is a result of a physical illness	-5	-1.524
45	Anti-depressant medication really helps me	-5	-1.551
46	I cling to the belief that there is a God who cares	-5	-2.314

Table A10: Factor scores for Factor 7

Factor 7: The 'blues'/ surviving through self-reliance			
Explained variance		7%	
Participants loading significantly on factor		3	
Number	**Statement**	**Grid**	**Z-score**
18	However bad it gets I know that I have to survive and get through it	5	2.235
43	Rather than burden others, I try to fix my problems for myself	5	2.045
34	My feelings could be best described as the 'blues'	5	1.725
37	I am aware that I need to get some sunshine	4	1.537
6	It feels as though the normal rhythm of my body clock is seriously disrupted	4	1.488
46	I cling to the belief that there is a God who cares	4	1.360
26	I know that I'm not helpless, I can get myself out of it	4	1.329
52	I worry about the effect that my depression will have on my family and close relationships	3	1.068
3	I feel as though others have no idea how truly awful the experience is	3	1.053
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out the window	3	1.004
24	I feel as though other people think I'm just being selfish	3	0.994
49	I fear being judged if I tell others about it	3	0.890
15	I find myself becoming more aggressive	2	0.840
38	Although it's difficult right now, I know it's part of the cycle of life	2	0.728
44	Professional help is the last thing I need	2	0.618
51	I feel ashamed of my depression	2	0.611
41	I find myself wondering 'what's the point of my life?'	2	0.583
11	**I feel sad and/or empty much or all of the day**	2	0.457
25	I get this internal voice which is negative and very critical of myself	1	0.403
40	I feel that I need answers to why this is happening to me	1	0.396
9	I have little or no interest in sex	1	0.368
39	I find myself struggling with the question 'how do you live this life?'	1	0.291
20	I find that sleep is my only escape	1	0.206
16	I am sometimes totally devoid of feeling	1	0.190
57	I find myself becoming secretive and paranoid	1	0.188
7	**I notice that most of the time my bodily movements have slowed right down**	0	0.181
4	I experience all sorts of aches and pains around my body	0	0.168
1	I experience a deep feeling of being alone and cut off from other people	0	0.141
54	I feel guilty that I can't just pull myself together	0	-0.061
2	Although on the outside I seem OK, on the inside I'm going through hell	0	-0.105
23	**I feel worthless and/or excessively guilty nearly every day**	0	-0.126
8	**I experience fatigue or loss of energy nearly every day**	0	-0.132
5	I feel tense and anxious most of the time	0	-0.138
17	I feel as though everything is hopeless	-1	-0.193
35	I know that it's the price I have to pay for creativity	-1	-0.205
29	I find myself taking many more risks than I would normally	-1	-0.227

14	**Most of the time my ability to concentrate and make decisions is diminished**	-1	-0.356
42	My life and the world seem meaningless	-1	-0.356
32	I have alternating periods when I'm down and when I'm up	-1	-0.374
30	Time seems to slow down for me	-1	-0.392
13	**My interest and/or pleasure in almost all of my activities is very diminished**	-2	-0.586
33	I feel as though something, like a chemical, has been released in my brain	-2	-0.638
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	-2	-0.657
27	No matter how hard I try I just can't take control of my thoughts and my feelings	-2	-0.739
53	I avoid seeing other people because I know I'll make them feel bad too	-2	-0.759
45	Anti-depressant medication really helps me	-2	-0.771
21	**I experience a decrease in my appetite nearly every day**	-3	-0.826
12	I find myself dwelling on the things that I've lost	-3	-0.851
31	I find it hard to imagine a different or better future	-3	-0.918
22	**I find myself sleeping too much nearly every day**	-3	-1.013
36	I am aware that it is a result of a physical illness	-3	-1.129
56	I find it hard to distinguish what's real and what I've imagined	-4	-1.145
48	I feel unsafe in my house, at work, everywhere	-4	-1.308
50	I'm not able to trust my senses, memory or my judgement	-4	-1.360
55	I feel more anxious because I don't know what's causing it	-4	-1.510
19	**I experience recurrent thoughts of death and of taking my own life**	-5	-1.830
10	I intentionally injure my body, for example cutting or burning my skin	-5	-2.146
58	I experience bizarre thoughts and delusions	-5	-2.247

Table A11: Factor scores for Factor 8

Factor 8: Loss of meaning/depression as part of the cycle of life			
Explained variance		8%	
Participants loading significantly on factor		2	
Number	**Statement**	**Grid**	**Z-score**
38	Although it's difficult right now, I know it's part of the cycle of life	5	2.004
9	I have little or no interest in sex	5	1.871
42	My life and the world seem meaningless	5	1.706
12	I find myself dwelling on the things that I've lost	4	1.574
17	I feel as though everything is hopeless	4	1.441
41	I find myself wondering 'what's the point of my life?'	4	1.409
28	My normal self-control, for example with smoking, drinking and recreational drugs, goes out of the window	4	1.143
13	**My interest and/or pleasure in almost all of my activities is very diminished**	3	1.026
40	I feel that I need answers to why this is happening to me	3	1.026
18	However bad it gets i know that I have to survive and get through it	3	1.010
2	Although on the outside I seem OK, on the inside I'm going through hell	3	1.010
8	**I experience fatigue or loss of energy nearly every day**	3	0.994
15	I find myself becoming more aggressive	2	0.994
25	I get this internal voice which is negative and very critical of myself	2	0.877
11	**I feel sad and/or empty much or all of the day**	2	0.877
55	I feel more anxious because I don't know what's causing it	2	0.861
39	I find myself struggling with the question 'how do you live this life?'	2	0.845
5	I feel tense and anxious most of the time	2	0.712
35	I know that it's the price I have to pay for creativity	1	0.680
27	No matter how hard I try I just can't take control of my thoughts and my feelings	1	0.579
23	**I feel worthless and/or excessively guilty nearly every day**	1	0.563
32	I have alternating periods when I'm down and when I'm up	1	0.532
43	Rather than burden others, I try to fix my problems for myself	1	0.415
1	I experience a deep feeling of being alone and cut off from other people	1	0.165
6	It feels as though the normal rhythm of my body clock is seriously disrupted	1	0.149
37	I am aware that I need to get some sunshine	0	0.133
16	I am sometimes totally devoid of feeling	0	0.016
26	I know that I'm not helpless, I can get myself out of it	0	0.000
30	Time seems to slow down for me	0	-0.149
44	Professional help is the last thing I need	0	-0.149
31	I find it hard to imagine a different or better future	0	-0.282
34	My feelings could be best described as the 'blues'	0	-0.282
4	I experience all sorts of aches and pains around my body	0	-0.282
14	**Most of the time my ability to concentrate and make decisions is diminished**	-1	-0.282
54	I feel guilty that I can't just pull myself together	-1	-0.298

7	**I notice that most of the time my bodily movements have slowed right down**	-1	-0.314
22	**I find myself sleeping too much nearly every day**	-1	-0.447
20	I find that sleep is my only escape	-1	-0.447
57	I find myself becoming secretive and paranoid	-1	-0.447
19	**I experience recurrent thoughts of death and of taking my own life**	-1	-0.579
47	Although anti-depressants numb the pain, they make me feel like I've lost a part of myself	-2	-0.680
3	I feel as though others have no idea how truly awful the experience is	-2	-0.696
53	I avoid seeing other people because I know I'll make them feel bad too	-2	-0.712
24	I feel as though other people think I'm just being selfish	-2	-0.712
33	I feel as though something, like a chemical, has been released in my brain	-2	-0.829
50	I'm not able to trust my senses, memory or my judgement	-2	-0.861
52	I worry about the effect that my depression will have on my family and close relationships	-3	-0.861
29	I find myself taking many more risks than I would normally	-3	-0.994
51	I feel ashamed of my depression	-3	-1.159
36	I am aware that it is a result of a physical illness	-3	-1.260
56	I find it hard to distinguish what's real and what I've imagined	-3	-1.260
48	I feel unsafe in my house, at work, everywhere	-4	-1.308
45	Anti-depressant medication really helps me	-4	-1.425
58	I experience bizarre thoughts and delusions	-4	-1.425
49	I fear being judged if I tell others about it	-4	-1.441
46	I cling to the belief that there is a God who cares	-5	-1.590
10	I intentionally injure my body, for example cutting or burning my skin	-5	-1.590
21	**I experience a decrease in my appetite nearly every day**	-5	-1.855

Table A12: Distinguishing statements for Factor 1 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 1	Q-sort	z-score
19	**I experience recurrent thoughts of death and of taking my own life**	5	1.76*

Table A13: Distinguishing statements for Factor 2 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 2	Q-sort	z-score
17	I feel as though everything is hopeless	-3	-1.12
39	I find myself struggling with the question 'how do you live this life?'	-3	-1.33*
25	I get this internal voice which is negative and very critical of myself	-4	-1.46*
42	My life and the world seem meaningless	-5	-1.58*
31	I find it hard to imagine a different or better future	-5	-2.09*

Table A14: Distinguishing statements for Factor 3 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 3	Q-sort	z-score
8	**I experience fatigue or loss of energy nearly every day**	-4	-1.26
23	**I feel worthless and/or excessively guilty nearly every day**	-4	-1.48

Table A15: Distinguishing statements for Factor 4 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 4	Q-sort	z-score
16	I am sometimes totally devoid of feeling	5	2.01
29	I find myself taking many more risks than I would normally	3	1.07

Table A16: Distinguishing statements for Factor 5 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 5	Q-sort	z-score
7	**I notice that most of the time my bodily movements have slowed right down**	3	1.01
44	Professional help is the last thing I need	-5	-2.30*

Table A17: Distinguishing statements for Factor 6 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 6	Q-sort	z-score
10	I intentionally injure my body, for example cutting or burning my skin	2	0.75*
19	**I experience recurrent thoughts of death and of taking my own life**	0	0.31
37	I am aware that I need to get some sunshine	-3	-1.26*
26	I know that I'm not helpless, I can get myself out of it	-4	-1.28

Table A18: Distinguishing statements for Factor 7 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 7	Q-sort	z-score
6	It feels as though the normal rhythm of my body clock is seriously disrupted	4	1.49*

Table A19: Distinguishing statements for Factor 8 (statements that were sorted significantly differently to all other factors), p = ≤0.05, * = significant at ≤0.01

No	Distinguishing Statements Factor 8	Q-sort	z-score
38	Although it's difficult right now, I know it's part of the cycle of life	5	2.00
49	I fear being judged if I tell others about it	-4	-1.44

Appendix 6

Samples of transcripts for focus group study

Focus Group 1: 'Non-clinical' group

4 participants; Location: University of Westminster

Facilitator: Dr Ian Hodges

Speaker key

S1 Speaker One (IH)

S2 Speaker Two

S3 Speaker Three

S4 Speaker Four

S5 Speaker Five

1. S1: I'll just make sure it's working. Yeah, so does anyone want to start just to kind of tell us about your picture, why you chose it, what it means to you?
2. S2: Yeah. My picture is focusing…so do I describe it for the audio or…?
3. S1: No, you don't need to but go ahead.
4. S2: Yeah, I mean that's…this relates to work, pressure in workload that we have over the last let's say two years really. So they did it for a change of work which increase, which was installing a new IT structure which was going to be a lot more beneficial to the staff and everything but actually it turned out…and they reduced the back office workforce by a significant amount in preparation for this new IT system which is going to be all singing and dancing but it was reverse effect so it's caused real problems at work for everyone we get across the workforce and just meant for prolonged working hours, work that we did, extra work that we had to do which we didn't do previously. So yeah, just long days and just… all you thought about was working. Not achieving all the deadlines but you were…well, not in a set that clients would basically ask for information and ask for non-achievement at all. So yeah, I mean that's over a really long period of time and I'm saying nearly two years. And you sort of basically or you know you basically had a cloud over your head [this references the picture] all of the time you know and you know just tired, long hours and what we thought about was working not really much else you know. Even on weekends you know and evenings you know being away from the work environment didn't help because then you'll have cues that would make you think of work or a name which reminds you of someone at work, guys at work possibly that you may think, "Oh, I've got to do this. I've got to do that." So it's quite a difficult period of time because that reminds you of something that you know you needed to do for the next day or that you haven't done or you know or something. So it's…wherever you were, whatever was it, yeah, you have all those cues kind of thing, remind me of work that needs to be done and that was overdue so that's quite a long period of time. And now I think we're sort of coming towards the end of it. So yeah, coming towards the end of it. And I think the organisation I work for are addressing it as well and that's probably what's helping everyone in the workplace. So yeah, that's my experience of it.
5. S1: …sounds like a lot of pressure.

6. S2: Yes, yeah. Intense pressure.
7. S1: Okay, so intense pressure.
8. S2: Yeah.
9. S1: Yeah. And there was something about,…I was wondering about the control thing. It sounds like these were changes imposed from somewhere else.
10. S2: Yes, yeah by the organisation I work for.
11. S1: Right.
12. S2: Yeah, they were imposed by them to assist us in getting the work done, changing the IT system, changing the IT systems that we use. We use possibly 20 different IT systems on the day-to-day basis and they brought that down to one IT system. So it was one-size fits all basically unfortunately and it didn't and that's what caused a lot of problems. So everyone had to use the new IT system. And as a result of the new IT system, they were told there will be a lot of time saved and money saved and they reduced the workforce, the back office workforce and that in turn caused a lot of pressure on the frontline workforce who had to then do that because that work wasn't then being done by the new IT software you know IT systems that way but that is…so yeah, that was imposed by the organisation I work for.
13. S1: Okay.
14. S2: No one had any choice in it. So that was an outcome as a result for a new structure, new software, new programs we use.
15. S1: So something imposed on you from outside. But there was something about being reminded…
16. S2: Yeah, it just gives us you know for example simple things about names even just simple names you know. Over the weekend if I you know if I'd heard a name or meet someone and said, "Oh, I've got to do this for the same name client maybe at work." You know that remind me of his name and you know the [inaudible 00:04:59] of her name. And I think, "Oh I need to do that work for them." Or for example tax you know, they have tax. Currently, we have…it's a tax time in the US just finished and in the UK, they have tax reporting. So anywhere you hear about them on news, newspapers and things like that. That's a sort of a busy period for us in the last six months. So you know that would be a key for our...the work done for these clients. So they requested this tax certificates that we need to provide for them for their tax returns. So there's the kind of cues which…which sort of followed you around you know outside work, not in the work but in the news or you know other side of the media so the papers. Yeah, so.
17. S1: Thanks, just one more last thing…
18. S2: Sure.
19. S1: …because if we go around to everyone first then we'll just open things up to see what you want to talk about. But can you think just for an instance what the feelings were? It sounds like you're doing a lot more work…
20. S2: Yes, yes.
21. S1: …than you were before.
22. S2: Huge amount of work. Yeah, a lot more work. That was actually undertaken by the back office staff.
23. S1: Yes.
24. S2: So we were having to do those work now.
25. S1: So you do all that as well as what you would normally do…
26. S2: Mm.
27. S1: So how did the pressure make you feel?

28. S2: Oh very, very, very depressed. Very anxious. I've not been able to see light at the end of the tunnel because the...you sort of have an audit trail of your work. So for example you have a to-do list and you know just a forever growing to-do list you know never really ending kind of thing which made it a lot you know which you didn't see any you know light at the end of the tunnel. You can't see things getting any better so.
29. S1: Yeah
30. S2: Yeah, it was just you know completely, totally sort of…Yeah, very, very down and very depressed kind of thing you know. And you know we had the pressure of having to deliver those...that work day on day. We couldn't just say that it wasn't getting done or get done or get done later on when we get around to it. It have to be delivered within sort of close at the timescales that the clients requested because they had to follow the tax sort of tax papers to the IRS or HMRC and things like that. So if you didn't, there's financial consequence which resulted in them complaining to my organisation. Yeah, they were complaining to the organisation I work for. And they were then obviously if they were at fault then they would need to pay for that. So if they would need to pay for that, they would need to then investigate well why do they need to pay for that. So that you know and then they'll see, it's someone fault at the bank you know. That from not doing that job in time so you know so that's even more pressure on you from your managers. So you know so its financial consequences if it's not done on time which is usually the consequence in the area I'm working.
31. S1: Okay, thanks for…thanks for that. I'll just hold on that for a bit.
32. S2: Sure.
33. S1: Does anyone want to go next with their pictures?
34. S3: Yeah, I might. This one kind of just reminded me of that feeling. I mean I don't actually smoke but sometimes when I have been low I think, "I'm going to smoke," you know. Or it's that kind of I don't really give anymore. I'm just going to have a cigarette or smoke and drink you know. You get so low that you think it doesn't really matter. Whereas my normal self-control will keep me from sort of even thinking about when I go drinking. So the look on the guys face here is kind of…yeah, when you get into that kind of just that guy which is trying to focus on nothing. Close your eyes, shut everything out kind of remind me of that sort of feeling on occasion that I have. That's what struck me.
35. S1: Is there something about switching off for you? Is that a sort of switching off or something?
36. S3: Oh you're kind of switching off, yeah.
37. S1: Right.
38. S3: Someone trying to make a sense to you as well so it's kind of switching off to everything that's going on and I suppose in that switching off, you kind of re-evaluate many things. You put things in focus. You can sort of recover it. But there is this period of like that sort of snapshots says it for me as that kind of…there's just so much pressure, responsibility, yeah, there's all these sorts of things that are on you in your life and you sometimes just have to stop and...before it breaks you. You have to sort of take that time out.
39. S1: Mm. Okay. So something about switching off, something about stopping, something about getting to a level where it's too much…
40. S3: Yeah.
41. S1: …or maybe overwhelming. Again, I'm just trying these words [Overlapping Conversation].
42. S3: No, overwhelming. Overwhelming is a good word, yeah.

43. S1: Okay.
44. S3: Yeah, I feel, that feeling of being overwhelmed with things, yeah.
45. S1: And I wondered about the smoking thing because that sounds like needing something or wanting something to help with it or is it different from that?
46. S3: Well, I used to smoke. I used to smoke a lot actually.
47. S1: Right, okay.
48. S3: And I suppose, I mean for me it will be that almost I don't really care anymore. It's what would take me over the edge almost. If I started smoking that would mean there'd be no…I would lose control I think if I started to smoke.
49. S1: Thank you, I'm just thinking in a sense the stopping might be taking care of yourself in a way. But you're saying it's kind of… maybe there's a point where it's like, "I just don't care. I haven't smoked for years but I'll just go on and get a packet of cigarettes.
50. S3: Yeah, sort of I was going to get something.
51. S1: Okay. Do you have anything else or…?
52. S3: That's it so it's a short one. (Laughter)
53. S1: No, no it's fine.
54. S3: I mean I could grumble about work and that would really....
55. S1: Short or long, that's fine. (Laughter)
56. S3: That would just put me into a bad mood. (Laughter)
57. S1: Yeah, that was very…it was all useful by the way. So [name removed].
58. S4: Um…okay, do you want me to go first?
59. S1: Yeah, please.
60. S4: Okay. I chose two images. One is of this man just sitting there all alone. And I guess in a way when I feel really low I feel isolated in my low feeling. And I feel somewhat removed from everybody else and can't really (Laughter)…can't really reach out to anybody else. So it's almost like this is how I feel. And the other image I chose was very much; it's about this woman walking in the rain. Two women walking in the rain and one has got an umbrella and the other one doesn't. And I feel that for me, I'm the one without the umbrella. So it's almost like everybody else is lovely and dry and happy and I'm the one who doesn't have an umbrella and I'm getting all wet. And I guess my…when I'm feeling that desperate and low, I feel like nobody else would understand or nobody else would be there. And I sort of feel like everybody else's life is perfectly okay and happy and cheery and then there's me who's alone in my sadness.
61. S1: It's interesting because it's very different, isn't it? And there's something about the image that I saw. I have this image of in a sense everyone else is having a good time when you look out. And at the same time for you this sort of feeling brings you away from people. Is that right?
62. S4: Mm. Yes, very much.
63. S1: So yeah.
64. S4: And it's…it's very debilitating and I think there is probably a fear in the debilitation because it's like, "How will I cope on my own?" And so there's the isolation but there's also the debilitating feeling of how will I cope with this?
65. S1: Okay.
66. S4: Thank you.
67. S1: We'll get more detail later. (Laughter) Okay. So [name removed], last but not least.
68. S5: (Laughter) Um…this image is quite literal because you can see a room, a tiny room. So I have to go back in time a bit because I live in London for about three years now. When I'm…before that I lived in [name of country removed]. And when I

came to England, there was a [inaudible 00:15:04] but it was very different living in London especially because you have to share your flat or your house otherwise it's really expensive. And in Germany you can easily have your own flat and place like that it had more flat. And I came to London and you basically can't get a shoebox for your money and you have to live in. And for me it's very, very important to have, not just my own space but a lot of space so and I want to feel homey in my room. So it needed to be really…you know what I mean? If you go home, you want to feel like relaxed and calm down if you have a lot of work for example. So that was my biggest depression last year. Yeah, two years ago I moved to London and I lived in a really good house and then we have to move out. And we had a flat and we had to share it though. I think it was a three-bedroom flat but we share the flat with four people so we had no living room. We only had our rooms. It was tiny and it was horrible and I felt really depressed because of that. And I start to hate London really. And then after eight months or something, we moved to a new house and it's big, it's lovely. So after that I felt really good. And it also kind of explains my depression when I put a lot of pressure on myself. For example work-wise because I always want to achieve a lot and I want to…I don't like failures so I always want to be really good in my job. And you come home and you don't feel or you don't feel good when you come home, that puts a lot of pressure on me. So I need, I need yeah a beautiful place really to live in. And yeah, I think that's it.

69. S1: Yeah, thank you. I'm struck by how much there is about home in all of that.
70. S5: Yeah, because I love, I love my home. I love my room basically.
71. S1: And you moved home in a profound way. You came from [country] over to London and you changed your location. And can you just say a little bit about the feelings? When you mentioned the depression, how would you describe how it felt?
72. S5: It is…I don't know maybe it's just, how do you say? If it's too small, the walls are coming towards you. You feel like that. It's just like, "Oh my god. I need to get out. I need to get out." And as I said then I need to when I come home I want to calm down and just relax sit on my bed for example and listen to music and feel good. And if I can't do that, if I don't feel homey then I'm like, "Oh shit, I need to get out." It's just, yeah. It's a very important part of my life really to have a beautiful home and wasn't able to have that last year.
73. S1: It's interesting how it's another different view of different things. And I was thinking with what…there's something about your environment…
74. S5: Yeah, very much.
75. S1: …in this home is something like what you said about you, what it's like where you are physically, where you are and how that might that affect you when that changes.
76. S5: And I think it kind of affects your whole life or my life because I put a lot of pressure on me anyway. And if I don't have a place to hide (Laughter) then yeah.
77. S1: So that…there's kind of retreat element, something like that.
78. S5: Yeah, exactly, yeah, yeah.
79. S1: Somewhere to go to.
80. S5: I feel safe, to feel safe, to feel comfortable.
81. S1: And if that's not quite as you wanted it
82. S5: Yeah, then you have more depression really.
83. S1: Yeah, yeah.
84. S5: I'm more depressed then.

Focus Group 2: 'Clinical' group

7 participants; Location: University of Westminster

Facilitator: Dr Ian Hodges

Speaker key

S1 Speaker One (Facilitator: Dr Ian Hodges)

S2 Speaker Two

S3 Speaker Three

S4 Speaker Four

S5 Speaker Five

S6 Speaker Six

S7 Speaker Seven

S8 Speaker Eight

85. S1: Okay, so. So what I would like to do is just go around and just get each of you to talk about the pictures, what they remind you of and so on. So, does anyone want to begin?

86. S2: I'll go. Actually it's this one because actually like when I'm depressed I find it really hard to be sociable and I don't want really to see people. I don't know if it's because I just…I don't know if they'll understand or I just feel quiet and therefore I feel really self-aware and uncomfortable in a social setting. So I tend to just kind of stay in my room and turn away from people. And it's hard that you talk about because your mind is quite scrambled about exactly what the cause is. It's hard to kind of verbalise why you're feeling how you're feeling. It's easier to just to kind of escape.

87. S1: Okay. And is that different to how you normally are or…?

88. S2: Yeah, I can be quite a social. But if I'm in a particular mood and I have felt that I'm trying to teach myself when I am feeling down or depressed to kind of force myself into a social situation especially with good friends because I feel that helps me. Like I sometimes feel like I, that people that I trust…I don't really trust that people understand or get it and they do you know like most people and that's been a learning process and then feeling safer to just kind of go out and if you're feeling quiet, be quiet and just be whatever state you're in and then it kind of helped to relax and kind of open up a bit more and feel better I think. But it's been a hard thing to learn. I'm still not very good at it.

89. S1: Mmm. It sounds like something that you do have to make yourself do this or…?

90. S2: Kind of yeah.

91. S1: Right.

92. S2: Yeah, yeah, I do. Sometimes it doesn't work, sometimes it ends up leaving or feeling a bit fragile but it can be really good for me I think because I think that my

depression's often link to anxieties so like a social anxiety kind of you know exacerbates it a little bit I think.

93. S1: So there's something about moving away from others? Is that right?

94. S2: Yeah, yeah. There's a couple of people I think in my life that I feel okay being that way with them but only a couple.

95. S1: And just one more thing, you can just…again, I want you to answer what you feel comfortable with.

96. S2: Yeah.

97. S1: But so there's something in the moving away from others is there something about not showing yourself? I'm just trying to understand that.

98. S2: I think so. I think it's like a self-consciousness about being depressed you know…

99. S1: Right.

100. S2: …and being like a drag on other people. Or it also not making sense in a way like it's not a reason like it's easy. It should be like you know that I'm able to think that I'm sad for this reason you know. I failed an exam. I broke up with my boyfriend, whatever it is, that's much easier to talk about. But I think depression for me is more like this kind of like you just don't know really what the source is sometimes and it doesn't make sense. So it's easier just to kind of turn away.

101. S1: Okay. Thank you. Thank you for starting as well. So anyone else want to go next?

102. S3: I chose this one because she's in…it seems to be sunny, nice weather and nice environment. There seems to be no reason to be depressed but she is kind of sulking. And I associate that with…even though I have no reason, supposedly no reason to be depressed you still kind of feel depressed and that sets the frustration. And also that kind of pressure to be happy. That's where depression often comes from for me. That sense of kind of needing to be [inaudible 00:04:25] and get on with things and enjoy what you have and make the most of the things and to succeed. So, but then still to feel depressed is a sense of kind of I guess failure or not being able to sort of get on in that but yeah. So that's why I chose that one. But again, I agree with [name removed]. Depression for me is that ambiguity not knowing what the source. If I feel sad, I'm sad about a particular thing and it's quite clear how to process that or deal with that. The depression is that murky ambiguity as to where it's coming from and not knowing what to do about it. And it…like in the situation perceiving it. You can't understand why you should be depressed and they have negative...on the surface, there seems to be no reason why it should be.

103. S1: Mmm. I'm struck that might also…there's something about not knowing the cause yourself and there not being an obvious reason.

104. S3: Yeah and you don't want to come across as being sort of mope or not maybe….

105. S2: Yeah, you feel kind of guilty that you are because you can't explain it like and you should, like have the most lucky, fortunate life ever and it something as the same thing as my life I can't explain it sometimes and I kind of beat myself up over feeling this way because it's absolutely no reason you know which kind of is a bit of confusing and a struggle. (Laughter)

106. S3: There's no place for it and there's no understanding in…in cultural society. There's no…there's no, yeah there's no place for it.

107. S4: I find it also becomes like a bit of a battle between wanting to not burden others whether or not get [inaudible 00:06:27] but then also trying to sort of, I guess a cry for help a little bit and try to want people to sort of find out and ask you and sort of help. But even that you don't so it becomes this kind of two-way thing where

you know…you don't know the source and you don't know it yourself but you want, so you don't want to like burden others but then you just don't want to…you don't want to cope alone.

108. S2: (Overlapping Conversation).

109. S3: You don't want to be a drag.

110. S1: Thank you. Anyone else? Who wants to go next?

111. S4: I'll go next.

112. S1: [name removed], do you want to go next?

113. S4: Sure.

114. S1: Okay.

115. S4: So these two. This one, that's what I chose because it's a bottle and for me depression is kind of linked with alcohol in a way. I'm not really sure of the relationship between the two yet but they…it exists in some way. I don't know…

116. S1: Okay.

117. S4: I don't know if it's causal or if it's you know often it's sort of self-treatment and escape. Sometimes it exacerbates it but sometimes it also can actually like help it sometimes. I feel like if you have, you'd have a drink with friends and you sort of forget about and then it can…but other times, it doesn't work at all and it sort of comes back. But also I think there's like a link between that and the idea that when you're not depressed and you're happy, a lot of the…a lot of the format in which we share that happiness with others well, me and my friends anyway is drinking so you go out. When you're happy, you go out and you drink and it's really fun. So then a lot of the time, if you're depressed you drink because you want to sort of relive that kind of you know that sort of happy, social environment when really you're not feeling like that. And then if you're drinking, when you're feeling like that it can often make it worse. So I think it can be hard to sort of be honest about how you're feeling and then sort of react to it accordingly like with the sort of social, being social and being with people and drinking. And also in my family, we've got like a history of sort of depression and alcoholism amongst like the men so. And also it comes into this kind of fear thing about you know like I'm sort of scared of that, of drinking and feeling depressed because anything like, "Am I going to….?" And you know but then you don't want like to not drink at all because it's something that you do for fun with your friends and so yeah, it's linked somehow through alcohol I think.

118. S1: Okay. So there's something about alcohol and coping which may or may not work and I get the sense…again, you have to tell me when this is wrong. I...got a sense that you might not know actually if it will work or not…

119. S4: Yeah.

120. S1: …and also it's something perhaps for you that's a bit different perhaps to some others which is if you have a history in your family then that might already be in your mind and have some kind of influence or at least colour the way you think about.

121. S4: Yeah. Well, that's…I'm never sure whether it's like you know if that's a genetic thing, can be a genetic thing. But I don't know if it's just like your awareness of that existence or that history can be influencing it or whether it is just purely the genetic thing because often just, as soon as you become aware that that's there, then the fear of it you kind of like, becomes like a psychosomatic exacerbation of that thing and it becomes this fear thing. So you'll never know whether it is actually that you have that gene or I don't know if the genes are really there or whatever so.

122. S1: So that's a mixed feeling as well?

123. S4: Mm.

124. S1: That together?

125. S4: Yeah.
126. S1: Okay. Thank you very much. Thank you, [name removed]. So anyone else?
127. S5: I think for me a lot of the time I feel like I'm kind of opposite to yours. I feel like I know the cause of the depression but there isn't much that I can do about it and there is an acceptance of things that every now and then this deep hole is open again and there's nothing you can do about it until something makes that okay again. And yeah, I guess whatever that something is it changes each time. And so yeah, maybe that is not knowing what that will be. But I chose this picture. Because it feels yeah, very like isolating and heavy like lead and dust at the same time. And I also chose this picture because sometimes I feel it's…there's so much happening in like so much of what is being processed, it's all in the head. But then when you look at yourself in the mirror, you don't even recognize who that person is.
128. S1: Thanks, so there's something, I'm struck that for you there's something different, that you feel that you know there's something causing the depression?
129. S5: Mm.
130. S1: Is that right? …or you think the cause is the same or…?
131. S5: I think often it comes back to the same thing. And um…I guess like it's like of the family and not having any support or network in that way. And yeah, I think and some other things you know that spread off from that but I think a lot of the time in the end it does kind of cycle back to that in a way. And different things can, can trigger it. But yeah.
132. S1: Okay. Thank you.
133. S3: Can I just say something?
134. S1: Please yes
135. S3: I agree with what you said about you know I guess I could say that I do, could feel depressed about something in particular but the ambiguity then comes from like you said not knowing how, what to do about it, how are you going to get out of that, this problem. So like say if I was sad about someone dying, I wouldn't call...me personally I wouldn't call that depression because it's just a problem and there's no you know. You just got to deal with it. But having, almost having like a problem that you could possibly solve in some way that you could but not knowing how to get out of that or how maybe whether you've been stuck in the dilemma as to how to deal with this problem. So then that ambiguity comes back and so whether you're being sort of selfish or unreasonable or something.
136. S4: I think sometimes it's wrong with looking for like…I know what you're saying about sort of possibly knowing the reasons but a lot of the time it feels as though that that's like a story you've created or like…
137. S5: Yeah.
138. S4: …through you know you look out for your history or past or whatever, whatever may have happened and you sort of create a story around it and you think maybe this is to construct this narrative to give it like you know a basis for where you sort of, depressions come from but then you're not really sure if that's the right reason anyway. So things like, I'm going to go like push down some path of trying to solve but we don't really know if that's the way yeah.
139. S3: Only if it's a reason like maybe just complain when you shouldn't.
140. S5: Or unlike….
141. S4: Yeah, it's like get on with it kind of….
142. S2: Or it's just giving you a basis like to me, "Okay, that's what it is. That's what it is." (Laughter)
143. S5: It sounds like you kind of want to know so you can have some relief.
144. S2: Yeah.

145. S5: You can put it then you can fix it. But you can't because it's harder to fix.

146. S2: So it's that sense of like another problem which is kind of more straightforward and practical and you can find a solution even if there's a cause when in it that stage there's like you don't have the energy or initiative or objectivity to kind of solve it you know. It's like so murky and you can't kind of approach as an objective problem or to see in a different way it's because you have got lost in it you know.

147. S1: Thank you. So we have three people left.

148. S6: I can go next. I speak French so it's very hard for me to explain it so I'll try my best.

149. S1: That's fine. Take your time.

150. S6: (Laughter) Well, I choose this one just because the stare that…so you have the person because for me all the time, I'm depression like you get scared. It's like let's have…it's I assume lots of thinking, lots of not sleeping. It's also like a big pile of links you know like [inaudible 00:16:18] so it's like you want to see anything or not be able to, it's just lots of like kind of negative things at the same time but you're so stuck into yourself that you can't really figure out you know which way then you…you feel like, you're so much into yourself that there's no way out of the issues. And, but for I'm going to say I'm not really used to talking about it because...

151. S1: That's fine. That's fine.

152. S6: But for me it's really about, yeah not being able to achieve things whether it's a small thing or not. So I could go from extreme laziness to not taking care of yourself, not going to work, not answering to your friends and also like again it's, it's a tricky, quite a tricky game because you can't really…even though you can't really put an event on it or one thing on it, it's a blend of let's say of different human reaction like frustration you know so like I don't know. You know of being tired and not really being happy in general or that type of self and…I mean of course that makes sense but I think that's the reason why nobody can really explain, yeah that's here because that's too…yeah, that's too tangled into…and there's also this horrible feeling of not, yeah, again I've not…because you have some of these things in your head like you can't really…you're like, "Oh my god. I'll never be able to do that kind of thing because I have to pay my bills. I have to pay this and that." So it starts from here but ends just like really build up and then I just go back to…to other foundation pretty much of what you've learned from your parents, in education then having friends and…so it's always like you question yourself about everything. So for me, that's the reason why I chose this picture because it just makes you guilty. You lie because you can't really…again, it's like stillness like you can't even move.